ISSUES RELATED TO MEDICARE PAYMENT POLICIES FOR HOME HEALTH AGENCY AND SKILLED NURSING FACILITY SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

JULY 23, 1996

Serial 104–82

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

39–485 CC WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-055313-X

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Public Laws / House / Hearings / 104th 2nd Session / 1996

CONTENTS

Page

Advisory of July 16, 1996, announcing the hearing 2

WITNESSES

Health Care Financing Administration, Bruce C. Vladeck Ph.D., Administrator 5
Prospective Payment Assessment Commission, Joseph P. Newhouse, Ph.D., Chairman, accompanied by Donald Young, M.D., Executive Director 41

American Health Care Association, and ADS Group, Newton, MA, Susan S. Bailis 133
American Hospital Association, John C. McMeekin 147
National Association for Home Care, and VNA Healthcare, Inc., Hartford-Plainville, CT, Margaret J. Cushman 84
National Association for the Support of Long-Term Care, Laurence F. Lane 153
Outreach Health Services, Austin, TX, and PPS Work Groups, Phillip I. Hoffman 95
Visiting Nurses Association of Greater Philadelphia, and PPS Work Group, Stephen W. Holt 65

SUBMISSIONS FOR THE RECORD

American Association of Homes and Services for the Aging, Sheldon L. Goldberg, statement 163
Home Care Association of America, Jacksonville, FL, Dwight S. Cenac, statement 172
Home Health PPS Work Group, James C. Pyles, letter and attachments 182
National Association for Home Care, statement and attachments 187
Premier, Inc., James L. Scott, statemcnt 199
StatChek, Inc., New Haven, CT, Raymond N. Altieri, Burgess A. Harrison, David S. Cole, and John P. Clark, statement and attachment 201

ISSUES RELATED TO MEDICARE PAYMENT POLICIES FOR HOME HEALTH AGENCY AND SKILLED NURSING FACILITY SERVICES

TUESDAY, JULY 23, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:08 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 16, 1996
No. HL-21

CONTACT: (202) 225-3943

Thomas Announces Hearing on Issues Related to Medicare Payment Policies for Home Health Agency and Skilled Nursing Facility Services

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, announced today that the Subcommittee will hold a hearing to examine Medicare's payment structure and current efforts to develop prospective payment systems for services provided to Medicare beneficiaries by home health agencies and skilled nursing facilities. **The hearing will be held on Tuesday, July 23, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Home health and skilled nursing facility (SNF) services are among the fastest growing of Medicare's benefits. This growth results in part from Medicare's payment methodologies (which are in part cost-based), an increasing number of beneficiaries using these services, and from an increasing average volume of services. To illustrate, Medicare's spending for SNF services increased from $2.5 billion in 1990 to $10.3 billion last year, for an average annual rate of growth of 33 percent. Separately, Medicare's spending for home health services has become the program's fastest growing benefit increasing from $2.6 billion in 1989 to $16 billion in 1995, for an average annual growth rate of 35 percent.

Regarding Medicare's SNF benefit, Medicare covers extended care services provided in nursing homes for beneficiaries who require skilled nursing or rehabilitation services following a hospitalization. The SNF benefits are covered under Medicare Part A for up to 100 days per spell of illness. To be eligible, the beneficiary must have received inpatient hospital services for at least three consecutive days and must be transferred to a SNF usually within 30 days of discharge from the hospital. A physician must certify that the beneficiary is in need of such services, which can only be provided on an inpatient basis. Beneficiaries are required to pay a daily coinsurance charge equal to one-eighth of the inpatient hospital deductible for days 21 through 100.

The Balanced Budget Act of 1995, which was vetoed by the President, included a proposal which addressed SNF reimbursement and utilization issues. The proposal established a prospective payment system (PPS) and in the interim, developed policies to address the increased volume and utilization in SNFs with a view toward implementation of the new PPS system.

With respect to the home health benefit, both Medicare Parts A and B cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Persons must also be homebound and under the care of a physician who establishes and periodically reviews a plan of care for the patient. While a beneficiary can not become eligible for home health on the basis of needing only occupational therapy, this can continue eligibility for home health care coverage, even if intermittent skilled nursing care or physical or speech therapy are no longer needed. Home health care agencies

(MORE)

are currently reimbursed on the basis of reasonable costs, up to specified limits. Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Costs limits, however, are applied to aggregate agency expenditures; that is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by the agency.

Spending for home health has been growing at a faster rate than other benefits. Consequently, its share of total net Medicare spending has increased from 3 percent in 1989 to 10 percent in 1995. Almost all home health claims are paid out of the Medicare Part A Hospital Insurance Trust Fund, which is estimated to become insolvent in the year 2001. Home health spending as a percent of total Medicare Part A expenditures has increased from approximately 4 percent in 1989 to 13 percent in 1995. The Congressional Budget Office projects that spending for home health services will increase to $31 billion by the year 2002.

Similar to the SNF benefit described above, the Balanced Budget Act of 1995 included provisions to reform payment policies for home health agency services. These provisions, and recent modifications proposed by the Administration, will be the focus of the hearing.

In announcing the hearing, Chairman Thomas stated: "Despite the President's veto, we are committed to curbing the growth in the cost of the SNF and home health benefits and moving forward with a prospective payment system for post-acute care services in order to increase the rate of Medicare spending at a slower rate. We look forward to hearing from these witnesses about their recommendations on proposals put forth by Congress, the Administration, and the industry."

FOCUS OF THE HEARING:

The hearing will focus on Medicare's home health and SNF benefits, in particular, current payment methodology and prospects for implementation of a PPS.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, August 6, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

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Chairman THOMAS. The Subcommittee will come to order.

Today's Health Subcommittee hearing is on two of Medicare's post-acute care benefits: Home health and skilled nursing. As this Subcommittee has heard in hearings this year and last, Medicare spending for both home health and skilled nursing services has grown over 30 percent per year over the past several years and is projected to continue to grow at similar levels well into the future. These rising costs, caused primarily by an increased use of services, prompted the Congress to develop new payment policies for both home health and skilled nursing facilities.

Three times, in 1982, 1984, and 1990, Congress has directed the Department of Health and Human Services by statute to develop prospective payment systems for Medicare skilled nursing facilities. Also in 1993 OBRA conferees expressed an expectation that HHS would present such recommendations in time for "implementation no later than October 1, 1995."

Separately, again, on three occasions in statute, in the Orphan Drug Act of 1983 and in reconciliation acts in 1990 and 1993, the Congress charged HHS with developing a prospective payment approach for home health services. Congress is still waiting. That old adage, "if you want something done, do it yourself," applied to this new majority, and that is why we went ahead and did it ourselves. We included in the Balanced Budget Act of 1995 new policies that implemented separate prospective payment systems for both home health and skilled nursing.

We worked closely with the providers of these services and believe we developed proposals which would both address the significant increases in costs and streamline the administration of these benefits. Unfortunately, the President chose to veto the proposals.

Due to the veto, the challenges facing the Medicare home health and skilled nursing benefits remain unresolved. Now it is time for Congress, the administration, and the provider community to work to develop meaningful payment reform for these services, and I would define "meaningful" as payment reform which constrains the growth of Medicare costs while ensuring—"constrains" so no one can say it is cutting—the growth of Medicare costs while ensuring that beneficiaries receive medically appropriate care delivered in cost-effective ways.

Today we will hear from Mr. Vladeck for the administration and the Prospective Payment Commission on issues related to implementation of payment reforms, such as prospective payment, and from representatives of home health and skilled nursing facilities who have also examined these issues in great detail.

Having outlined the history of when Congress asked and the failure of a number of administrations to deliver, obviously these solutions are far more difficult than it might appear to the average viewer.

So, I welcome the distinguished witnesses to this hearing and would recognize the gentleman from California, the Ranking Member from California, Mr. Stark, for any remarks he may have.

Mr. STARK. Thank you, Mr. Chairman.

I think we may be saying the same thing in different ways. I am sure we agree that prospective payment for home health and SNF, skilled nursing facility, services, if not all post-acute care, is needed

and inevitable. And, as we see the change to managed care, the old traditional lines begin to blur. It is getting harder and harder to tell where acute care in a hospital stops and the hospital-owned home health care starts. In some cases, I think the hospitals may be gaming us by double dipping a little bit.

Of all the proposals, the administration proposal, the Republicans, the Blue Dogs, the Yellow Dogs, they all contained provisions for prospective payment in SNF and home health, but they differed in the amount of savings and the implementation dates. And so, I think you are right. I think it is complex, and it has tremendous pressure depending on who ends up getting more or less of the reduced pie, which puts pressure not only on us but on HCFA.

So, I would like to know more about the effect of the proposed changes. I might say relative only to this that the veto may have been a blessing and we may have a chance to look at this in more detail and direct HCFA in the right way. A recent GAO report shows that the growth in home health care is primarily due to the proprietary agencies. They provide more visits and longer episodes than government and nonprofit agencies.

Now, it is not clear whether they are providing better care or not, but there are a lot of issues to look at here, and I thank you for calling this hearing to see if we can figure it out. I, too, would like to get this show on the road.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Any other Members who may have written remarks can certainly place them in the record without objection. I would tell the Administrator that his written remarks will be placed in the record, and he can inform the Committee in any way he sees fit about the success, failure, marginal improvement, movement toward, soon to conclude, any other information that he might provide us on the question of home health and SNF payments.

STATEMENT OF BRUCE C. VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman. I appreciate the opportunity to appear before you today to discuss the growth in skilled nursing facility and home health agency expenditures and the development of prospective payment systems for those services.

When I first got into this business in the seventies, I used to say that part of the basic canon of every Medicare Administrator was that Medicare was not a long-term care benefit; Medicare covered only acute services. Certainly no one envisioned when the benefit structure of Medicare was first created the kind of circumstances in which we would find ourselves today.

In the current fiscal year, we will pay more than $28 billion for SNF and home health agency services and other post-acute services. While our rules still limit these services to beneficiaries who require skilled care, many of those services are furnished to beneficiaries who, by anyone's definition, are long-term care patients. Our projections now suggest that by the year 2002, under current law, expenditures for these services will be almost $55 billion.

The dramatic increase in our expenditures for post-acute services arise from demographic change, from a significant increase in the number of providers, from a decline in acute hospital lengths of stay, from changes in medical practices, and from the financial incentives for providers. We have seen a substantial increase in the number of beneficiaries using multiple post-acute services, and we have evidence that volume and intensity of services per user is also increasing.

But there have also been a number of policy changes that have encouraged the use of post-acute care. Some of these changes had unintended consequences, but almost all of them were undertaken in the belief that they would reduce total costs to the program by shifting resource use from more expensive hospital-based to less expensive post-acute care settings. For the most part, these were piecemeal changes attempted through the years to meet specific needs or to achieve specific objectives. The one thing I think we can say about all of them is that so far none of them has been demonstrated to have saved the program any money.

The Prospective Payment System for hospitals also created incentives for hospitals to establish hospital-based post-acute units in at least two ways: First, hospitals that have such units are better able to discharge patients early, thus doing better under the Prospective Payment System; second, the intersection between the reimbursement rules for acute hospitalization and for long-term care facilities permit hospitals to allocate a portion of their overhead to the long-term care unit and to receive cost-based payment for that part of their total operating costs.

The result of these policy changes and the incentives of the PPS, prospective payment system, has been to provide opportunities for providers to exploit the areas of Medicare where expenditure growth is less constrained, where the current law offers relatively few incentives for cost-conscious behavior, and where professional norms of appropriate quantities of practice are less well established.

There are a range of other outmoded policies associated with our current policies, including the new provider exemptions from cost limits for SNFs, rehabilitation, and long-term care hospitals, and the favorable presumption provision that long applied to SNFs, home health agencies, and hospices. We have closely monitored the growth in utilization of Medicare post-acute benefits. Much of the growth in utilization and expenditures has resulted from the industry responding appropriately to incentives created by the current system. But some of this growth has been the result of directly abusive or even fraudulent behavior. I want to assure the Congress that we have intervened aggressively with the tools we have available to us to stem the growth of this misuse of Medicare.

But of course, comprehensive control of post-acute care expenditure growth, as the GAO itself has reported, cannot be realized without legislation. As both the Chair and the Ranking Member noted, both the administration and the Congress have appropriately made payment reform for SNFs and home health a top priority in Medicare reform. There are areas where our policies diverge, but I, too, would emphasize the opportunity to find common ground on a broad range of issues.

Before I talk about specific legislative proposals, I would like to suggest that they should be viewed as means to an end, not an end in themselves. The real goal should be a post-acute care payment system that provides comparable incentives across delivery sites. While we should accelerate our efforts to develop prospective payment systems for each category of post-acute provider, we should not be permanently wedded to separate payment systems for each of these separate benefits. Rather, we should work to better understand the value of each post-acute care provider type and how to better manage and coordinate care across the continuum.

Our guiding principle in any lasting reform of our post-acute care benefits should be to make the system of services more beneficiary-centered by developing an infrastructure of post-acute and long-term delivery systems that is integrated and flexible in meeting the needs of those with chronic conditions.

In some possible future payment system, we would want to provide payments sufficient to ensure that beneficiaries receive high-quality care in the appropriate settings and that any movement among settings occurs only when medically appropriate and not as part of an effort to generate additional revenues.

Let me touch very briefly on the status of our payment demonstrations for home health and SNFs. We are testing two alternative methods of prospective payments for home health agencies. We have largely completed phase I of the demonstration which tested a per visit prospective payment system and demonstrated very little impact on total expenditures from that system. We began phase II of the demonstration in June 1995, and we are testing a per episode prospective payment system. We will draw on data from phase II and additional research to provide the necessary information to design a payment system that accommodates the full range of home health services covered under the program.

Without this information, for example, we cannot yet determine whether the definition of an episode we chose for the demonstration 120 days, is appropriate for a national payment system. Currently, 120-day episodes only capture about 60 percent of all home health care visits. If 120 days were to be used as the definition of an episode, that would mean that almost 40 percent of all home health visits would fall outside the basic prospective payment mechanism.

Also, last year we began the Multi-State Nursing Home Case-Mix and Quality Demonstration. We are testing a per diem prospective payment system for both routine and therapy services integrated with a quality monitoring system for SNFs. Today we have already learned a lot about how to appropriately design a prospective payment system for SNFs and what we would need in order to implement such a system. Whenever we have the legislative authority to proceed, we will have already done much of the legwork moving down the road toward prospective payment for SNFs.

We have relied on these experiences in formulating the administration's proposals for payment reform. In home health we plan a two-step transition to a per episode prospective payment system in 1999. I think there is broad agreement among representatives of the industry, many Members of Congress, and other experts that

for home health a per episode payment system is a superior way to constrain costs without sacrificing access or quality.

In our legislation, we have sketched out some of the features that are desirable for such a system, but in order to put one into place, we need authority which we do not currently have. We need the authority to request data from home health agencies that will support research and implementation efforts, to develop appropriate case mix adjusters, and to develop an appropriate definition of an episode of care.

While we are in the process of such development, we propose to implement an interim payment system that would allow us to achieve substantial savings.

The conference agreement proposal of last year called for the immediate implementation of a prospective payment system for home health. Agencies would have been paid a per visit prospective rate subject to an annual dollar cap that would be calculated to approximate all covered services delivered to a beneficiary during a period of 120 days, but would be applied up to 165 days' worth of services. Agencies that keep total payments for the year below the annual cap would be allowed to retain half of the savings. Numerous outliers and extended-care exceptions would be paid outside of the cap on a per visit rate.

We oppose this proposal because we do not believe that a payment system that permits as much as 30 percent of visits to be paid without utilization controls can guarantee the appropriate level of savings. We also fear that the use of inadequate case mix adjusters could create an incentive for agencies to avoid caring for heavy-care patients with the greatest needs.

Also, we believe the plan assumed too much about the extent to which the necessary data systems and information were in place in order to facilitate immediate implementation of prospective payment.

I know you are aware of our proposal to shift financing of a portion of the home health benefit from part A to part B. Under the President's proposal, the first 100 home health visits following a 3-day hospital stay would be reimbursed under part A. All other visits, including those not following hospitalization, would be reimbursed under part B, but would not be subject to the part B coinsurance or deductible. Also, this transfer would not affect the part B premium and would not change access to the benefit by beneficiaries.

Clearly, capping part A financing of the home health benefit saves the financially vulnerable Hospital Insurance Trust Fund on the order of $55 billion over 7 years, which I suspect was associated with this Committee's support of such a similar proposal last year. But there are deeper sound policy reasons for advancing this proposal.

The home health benefit, like the SNF benefit, was originally designed to provide short-term recuperative services to beneficiaries immediately following discharge from a hospital. As such, the benefit provided 100 visits under part A and up to another 100 visits under part B. To expand the benefit, Congress in 1980 removed the part A and part B visit limits and eliminated the hospital stay requirement, thus turning home health into an unlimited benefit.

An unintended consequence of OBRA 1980 was to burden the Hospital Insurance Trust Fund with almost all the financing of home health, regardless of whether or not the visits are related to a hospitalization.

The President's proposal to move a portion of the financing of home health back to part B restores the original part A coverage of post-hospital care services and uses part B to finance all other home health services. It maintains the congressional intent for a home health benefit that is available to all beneficiaries regardless of their part A or part B coverage. It also maintains the intent to have a home health benefit that does not require out-of-pocket expenses to be borne by beneficiaries.

Most importantly, it would allow us to focus for the future in two separate sets of coverage policies for two distinctly identifiable groups of home health users: Those who are in the acute recuperative stage following a hospitalization and those who are receiving home health care for chronic conditions.

Let me end this discussion of home health with a note of complete agreement. Both Congress and the administration wisely propose to permanently extend the savings from the OBRA 1993 freeze on home health cost limits by not allowing for the inflation that occurred during the freeze. As with home health, both the administration and the Congress agreed that the savings from the OBRA 1993 cost limit freeze should be permanently extended for SNFs as well.

With respect to SNF reimbursement reform, we are further along with our efforts and could implement a system as soon as we have the legal authority to do so. However, as with home health, we have proposed a two-stage process to allow transition to a fully prospective system.

For the interim system, we would establish an interim prospective rate for routine costs based on facilities' specific costs subject to regional limits. We would at the same time immediately eliminate the new provider exemptions and new exceptions to cost limits. We would require SNFs to bill Medicare for all services their residents received, prohibiting payment to any entity other than the SNF. This would also reduce beneficiary part B copayments for services covered under part A. To ensure that Medicare does not overpay for these services, we would also establish limits on ancillary services based on amounts payable for similar services provided on a fee-for-service basis under part B.

We are committed to moving from that transition stage to a full PPS for SNFs beginning in fiscal year 1998 provided we get the legislative authorization to do so. The prospective rate would be designed to cover all three SNF cost categories: Routine, ancillary, and capital-related costs.

Of course, last year's conference agreement also proposed a two-step movement to a full prospective payment system. One area of difference between the congressional and administration provisions is the unit of payment. The administration's plan does not specify whether PPS payments should be made on a per episode basis, as in the conference agreement, or on a per diem basis. We have decided not to specify a unit of payment until further research and

demonstration results can shed light on the appropriateness of one or the other.

To be honest, prospective payment systems have been in use for nursing home care—first in State Medicaid Programs, then under our demonstration—for more than a decade, and in every single instance, they have relied on the per diem as the unit of payment.

We are testing a per diem approach on a demonstration basis in six States and have no comparable experience with per episode payment systems. But we will have sufficient data from our case-mix demonstration and experiment to develop a per episode payment system for SNFs should we be convinced that that would have better effects on patient outcomes, quality, or access to care.

Now, we also disagree with the conference agreement's provision that places limits on ancillary, non-routine payments separate from the basic prospective payment system. We are concerned that those limits could place patients at risk of inadequate services. We would provide somewhat different control on those expenditures through their incorporation into prospective payment.

In conclusion, I think we all agree that these expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that we need legislation to slow down the growth. I have laid out for you today our vision for the future of post-acute care payment. Because we do not yet have all the tools to implement this vision, we have put forth concrete proposals to modify payment policies for SNFs and HHAs as I have described them.

There are some significant differences between our proposals and those that this Congress enacted, but we think the commonalities outweigh them. It is my hope that we can work together to develop payment policies that provide the right incentives—incentives to provide quality care, promote access to care, and inhibit fraud and abuse. We look forward to the process of working together with you in that enterprise.

I appreciate again the opportunity to appear before you today.

[The prepared statement follows:]

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR
HEALTHCARE FINANCING ADMINISTRATION

Medicare Payment for Home Health Agency and Skilled Nursing Facility Services

Introduction

Thank you, Mr. Chairman, for the opportunity to testify today. I am pleased to discuss the growth in skilled nursing facility (SNF) and home health agency (HHA) expenditures and our plans for developing prospective payment systems for these services. We are committed to doing payment reform and moving quickly to enact it.

When I first encountered these issues in the late 1970s and early 1980s, Medicare was used primarily as an acute care benefit, and nobody envisioned that it would cover as much long-term care as it does now. However, times have changed. In 1996, Medicare will pay for more than $28 billion in post-acute services -- mostly SNF and HHA services, but also including rehabilitation and long-term hospital care. While Medicare rules still limit these services to beneficiaries who require skilled care, many of these services are furnished to beneficiaries who are long-term care patients. Currently, more than 15 percent of total Medicare program dollars pay for post-acute services, as opposed to about 3.5 percent of program expenditures in 1986. The President's FY 1997 budget projects that, in 2002, expenditures for post-acute care services will be more than $54.7 billion.

Expenditures for post-acute care services are among the fastest growing components of Part A and total Medicare spending. However, these expenditures represent just the tip of the iceberg on spending for long-term care patients. Although the majority of nursing home stays are not covered by Medicare, many of the individual health care services used by nursing home residents are covered -- such as hospital care, physician visits, and therapy services.

The number of Medicare-certified SNFs has grown 38 percent since 1986, from 9066 to 12536 (including a more than a 250 percent increase in hospital-based SNFs). Home health agency growth has been even more dramatic. In 1986, there were 5907 home health agencies, compared to 9200 currently -- a 56 percent increase. The increased supply has permitted more utilization. We have seen a substantial increase in the numbers of beneficiaries using both SNF and HHA care. In 1984, 298,000 Medicare beneficiaries used 9.6 million days of SNF service. In 1994, about 925,000 Medicare beneficiaries used 36.9 million days of SNF care. Similarly, in 1984, 1.2 million Medicare beneficiaries had 31 million covered HHA visits. This increased to 3.2 million beneficiaries receiving 209 million covered visits in 1994. Further, we have seen evidence that the intensity of services per user is also increasing. SNF patients are receiving more therapy and other services during their stays, and HHA patients are using more services, up from 25 visits per user in 1984 to 65 visits per user in 1994.

Reasons for the Growth in Post-Acute Care Utilization/Expenditures

Let me highlight just a few of the reasons why such explosive growth in utilization and expenditures occurred. These include policy changes, incentives created by antiquated cost-based reimbursement systems, changing demographics, medical advances, and increases in demand by beneficiaries and physicians.

Policy Changes

First, a number of policy changes have encouraged the use of post-acute care. While some of these changes had unintended consequences, many of these changes

were undertaken with the belief that they would reduce total costs by shifting resource use from more expensive (hospital) to less expensive (post-acute care) settings. For the most part, these policy changes were not systematic attempts to reform Medicare. Rather, they occurred piecemeal throughout the years to achieve specific objectives. And, we have found, they have not reduced overall program costs.

Example: Home Health Benefit Expansion

Let me discuss the expansion of home health coverage and eligibility as an illustration. As you are aware, OBRA-1980 removed the 100 visit limitations under Part A and Part B and also eliminated the 3-day prior hospital stay requirement. In effect, OBRA-1980 transformed the home health benefit into an unlimited benefit -- one that serves the chronic, long-term needs of patients as well as the needs of those who require recuperative care after a hospital visit. In response to the potential increase in utilization due to the OBRA-1980 expansion of the benefit, HCFA attempted to restrict utilization through administrative measures -- namely, we interpreted, where possible, coverage and eligibility requirements in a more narrow fashion. However, these attempts were thwarted by a 1988 court case, Duggan v. Bowen, the settlement of which resulted in a re-interpretation of the "part-time or intermittent" eligibility criteria in a way that vastly expanded the benefit's coverage. The confluence of the OBRA-1980 changes and the Duggan settlement had a dramatic impact on home health utilization, as noted by the General Accounting Office (GAO) in its March 1996 report on Medicare Home Health Growth (GAO/HEHS-96-16).

In the aggregate, as a result of the OBRA-1980 changes and the Duggan settlement, we have witnessed a steady growth in the number of home health visits per beneficiary per year. Much of the growth in home health outlays is due to patients who receive more than 100 visits per year. The Duggan settlement alone is estimated to have resulted in a 38 percent annual increase in home health expenditures from 1988 to 1992, and a 167 percent increase in visits per beneficiary from 1989 to 1995.

OBRA-1980 also allowed for Medicare certification of for-profit home health agencies. Proprietary agencies -- which now represent 48 percent of all certified agencies -- are the fastest growing segment of Medicare home health expenditures. One analysis suggests that beneficiaries receiving care from proprietary HHAs receive 21 more visits, on average, than those receiving care from non-profit agencies, after controlling for the differences in health and functional status of the beneficiary, as well as age, sex, and living situation.

Incidentally, the OBRA-1980 legislation resulted in the Hospital Insurance Trust Fund financing approximately 99 percent of the financing for the home health benefit, regardless of whether or not visits are related to a hospital stay. As I'll explain later, this is a problem we seek to fix in our legislative proposals.

Example: SNF Coverage Guidelines and the Impact of the Medicare Catastrophic Coverage Act of 1988

SNF utilization and expenditures have also increased as a result of a number of policy changes over the years. In April 1988, we clarified the SNF coverage guidelines based on evidence that the existing guidelines were interpreted inconsistently across fiscal intermediaries, resulting in arbitrary and excessively restrictive claims determinations as well as geographic differences in SNF coverage. In some areas, beneficiaries did not apply, or were not encouraged to apply, for Medicare SNF coverage because of the possibility of retroactive denial of their care. After

implementation of the new coverage guidelines, retroactive denials decreased significantly.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) was designed to change the Medicare benefit structure to cover catastrophic conditions more fully. Several aspects of the SNF benefit were changed under the law, including the elimination of the 3-day prior hospital stay requirement, changes in the copayment, and broadening of coverage (to 150 days in a calendar year). As you know, the MCCA was subsequently repealed in 1989. However, that was not before the industry responded to expand SNF utilization. The elimination of the prior hospital stay requirement and the broadening of coverage led to the potential that Medicare coverage would be substituted for Medicaid coverage of nursing home care. This was especially likely since the OBRA-1987 changes in nursing home certification made Medicare and Medicaid requirements virtually equivalent. In some cases, States actively recruited facilities to obtain Medicare certification so that they could bill Medicare whenever appropriate. The increase in the number of Medicare-certified facilities was dramatic. The increase in capacity that indirectly resulted from MCCA, coupled with the clarification of coverage guidelines, led to explosive growth in SNF utilization in the late 1980s.

Example: Impact of Hospital PPS

Finally, the implementation of the Prospective Payment System (PPS) for inpatient hospitals also resulted in increased utilization of post-acute services. Hospital PPS provides payment to hospitals on the basis of the medical characteristics of the patients they treat, rather than the resources they expend in providing care to patients. Hospitals responded to the incentives in PPS by shortening the lengths of stay. Patients were discharged earlier, with less complete recovery, resulting in increased use of post-acute services. There has been a significant shift in Medicare spending from PPS hospitals to post-acute providers. In 1986, acute care hospitals received more than 91 percent of Medicare Part A payments whereas post-acute care providers received less than 9 percent of Part A payments. In 1993, however, the percentage of Part A payments to hospitals decreased to less than 74 percent in 1993, while payments to post-acute care providers increased to more than 26 percent.

In fact, PPS not only created incentives for hospitals to discharge patients earlier, but also to establish hospital-based units for post-acute services. In 1994, almost 60 percent of hospitals had a post-acute care unit (e.g., a rehabilitation unit, SNF, or hospital-based HHA). These hospital-based units benefit hospitals in two ways: first, hospitals are better able to discharge patients early, thus profiting under the PPS payment system. Second, HCFA's reimbursement rules allow hospitals to allocate a portion of their overhead to the distinct-part unit, and they receive cost-based payment for these services.

Cost-Based Reimbursement Systems Provide Few Incentives for Cost-Conscious Behavior, Invite New Market Niches, and Allow Room for Fraudulent and Abusive Practices

The result of these policy changes and the incentives of PPS has been to provide an opportunity for providers to exploit the areas of Medicare where expenditure growth is less constrained, and where current law offers relatively few incentives for cost-conscious behavior.

Payment for post-acute care services is still based on cost reimbursement subject to limits, and does not incorporate utilization limits. Relative to hospitals, the norms of

professional practice in post-acute care providers are less well established. Thus, utilization limits may be more necessary than in acute care.

These cost-based systems are accompanied by other outmoded policies, such as the new provider exemptions from the cost limits for SNFs, rehabilitation, and long-term care hospitals, and the favorable presumption provision that applied to SNFs, HHAs, and hospices. The favorable presumption was designed as a shorthand means of carrying out the limitation on liability protection that is afforded beneficiaries and providers under the law -- but it was a shortcut that went well beyond the intent of the limitation on liability protection. It forced us to automatically pay for non-covered care. We believe this was harmful to the best interests of Medicare program integrity.

The industry's interest in defining a subacute care benefit is another example of providers pursuing opportunities in less constrained areas of Medicare. Industry proponents have created a subacute care "market" financed primarily by Medicare. Providers market these services to patients who would traditionally have received a longer inpatient hospital stay, and are generally sicker than traditional SNF patients. The major providers of subacute care are SNFs, which receive exemptions and exceptions from the payment limits to provide high level care to Medicare patients, although long-term care and rehabilitation hospitals are also providing subacute care.

The Department of Health and Human Services, under the auspices of the Offices of the Assistant Secretary for Policy and Evaluation (ASPE), has just completed a two-part study of subacute care. The study included a synthesis of the literature and research on subacute care, and a market area analysis of subacute care in four markets. The study found that there is no agreement on a specific definition of subacute care, although there is increasing consensus about the characteristics of subacute care patients and the key elements of an "ideal" subacute care program. While many providers incorporate some of these elements into care, few providers incorporate most of these elements. Thus, much of what is called subacute care is "old wine in new bottles" and marketing is ahead of the product.

There is scant information about the costs and potential public savings associated with subacute care apart from industry estimates. In general, these industry studies significantly overestimate the potential for public savings associated with subacute care. Although a sub-acute benefit may have the potential to decrease hospital lengths of stay, Medicare could end up paying for care twice -- once for the initial hospitalization and again for the subacute care stay -- for patients who would have ordinarily remained in the hospital.

The current payment systems have created a climate that, if not actually encouraging abuse, does not do nearly enough to prevent abusive practices. Under current program policies, providers and suppliers' billing practices are fragmented and uncoordinated, resulting in inappropriate and excessive Medicare charges and payments. For example, a therapy provider may bill Medicare for therapy services provided to nursing home residents. Certain supplies can also be billed directly by a supplier. These polices also encourage abusive billing practices where Medicare is billed for services and supplies that residents do not receive or services that are not medically appropriate or effective (e.g., do not improve patients' functioning). Further, these policies put beneficiaries at risk of out-of-pocket liability for Part B coinsurance for services that could have been furnished under Part A. In an effort to ensure quality oversight consistent with the OBRA-1987 reforms, we are seeking to change these policies. Our desire is to ensure that nursing homes coordinate the provision of, and consolidate the billing for, all services that are provided to residents. But an important secondary effect of these

changes would be to signal an intolerance of abusive practices.

Other Factors

I do not want to leave you with the impression that it was policy changes alone that created the explosive growth in post-acute utilization and expenditures. Changing demographics, medical advances, and increases in demand by beneficiaries and physicians have all contributed to this phenomenon. Medical advances, for example, have expanded the range of patients who can benefit from certain therapies, and have made it possible to provide interventions (such as intravenous drug therapy) in less intensive settings. Certainly, shifts in demographics have had an immense impact on the use of post-acute and long-term care services. For example, the over 85 age group is the most likely to use nursing home services, and this age cohort has increased by 34 percent in the last 10 years. Studies also show that home health care is serving many more of the older elderly population who require longer term care. Physicians and beneficiaries are increasingly showing a preference for home health care over other modalities. Finally, there has been a growth in marketing efforts toward physicians by HHAs to stimulate demand.

HCFA Administrative Efforts to Stem the Growth of Inappropriate Utilization and Costs

HCFA has closely monitored the growth in utilization of the Medicare post acute care benefits. Much of the growth in utilization and expenditures has resulted from the industry responding to incentives created by the policy changes I've described. However, some of this growth has been the result of inappropriate utilization of the Medicare post-acute benefits. I want to reassure the Congress that we have intervened where possible to stem the growth of inappropriate utilization. The following are some of the efforts we have undertaken, or are undertaking, to address this concern.

Home Health Care

Three years ago, I commissioned the Medicare Home Health Initiative, an agency-wide, comprehensive assessment of the home health care benefit. The Initiative involved consultation with representatives from consumer groups, the home health industry, professional organizations, fiscal intermediaries, and State agencies. The Initiative has spawned various efforts to make a number of improvements to the benefit and, where possible, assert greater control over its utilization.

We are in the process of revising the home health Conditions of Participation (CoPs) in order to hold agencies accountable for better, more accurate patient assessment, care planning, coordination of service delivery, and quality assessment and performance improvement. We hope to publish a notice of the proposed changes to the CoPs shortly. We also recently overhauled our provider manual to provide better guidance to agencies on the complex home health eligibility and coverage rules; we would expect this greater clarification to reduce the amount of inappropriately furnished services that are billed to Medicare.

We have also worked to increase physician involvement in the monitoring of home care services. Physician involvement in care plan oversight is critical to ensure that the appropriate level of care is being provided. We need to avoid situations in which physician certification is merely a rubber stamp of a plan of care that has been completed by a home health agency. To achieve this goal, HCFA is now reimbursing physicians for complex care plan oversight, and we hope that recent increases to the

reimbursement amount will further engage physicians in the careful planning of home care services. We are also involved in a number of efforts to educate physicians about the home care benefit.

We are trying to better educate beneficiaries about the home health benefit in an effort to help them recognize instances of inappropriate care or fraud and abuse. We have published a new home health brochure and have produced a video to be shown in hospital and office settings. Beginning early next year, we will be sending a Notice of Utilization statement to inform beneficiaries of the services being billed on their behalf so that they can detect any aberrancies. Finally, HCFA is testing the impact of increased sharing of information between State survey agencies and regional home health intermediaries on ensuring that HCFA pays only for services that meet home health coverage requirements.

The December 31, 1995 sunset of the favorable presumption provision gives us an opportunity to reduce the number of inappropriate claims that had previously been automatically paid. We support continued limitation on liability protection for a provider where it can, on a post-denial basis, demonstrate that it and the beneficiary did not know, or could not have known, that the service furnished was not covered by Medicare. However, we believe that the limitation on liability protection should not be broadened once again to shield excessive and, in some cases, abusive billing practices.

We will continue our diligence in attempting to stem the tide of inappropriate home health utilization. As the GAO noted in its March 1996 report on Medicare Home Health Growth, HCFA is working to gain greater control over the use of the home health benefit. We appreciate the GAO recommendation that the Congress consider providing additional resources to HCFA so that controls against abuse of the home health benefit can be better enforced. As you are aware, we have engaged in numerous efforts to deter and detect fraudulent and abusive practices in the home health industry through our Operation Restore Trust (ORT) demonstration and the Medicare Home Health Initiative. We also note that the GAO suggested that Congress may wish to consider whether the home health benefit should continue to become more of a long-term care benefit or if it should be limited primarily to a post-hospital acute care benefit.

SNF Care

For SNFs, we are in the process of establishing, by regulation, guidelines for payment of therapy services. Medicare has long had guidelines limiting the reasonable cost of the physical and respiratory therapy services provided by outside suppliers for clinics, rehabilitation agencies, public health agencies, or other providers of services. Under these guidelines, the reasonable cost for such services cannot exceed an amount equivalent to the salary and other costs that would have been incurred in an employment relationship, plus an allowance for costs, such as travel, that an individual not working as an employee might incur. HCFA has been working to revise the existing salary equivalency guidelines for physical and respiratory therapy, and to develop such guidelines for occupational therapy and speech language pathology. The GAO has concluded that these guidelines are necessary to prevent abusive billing practices. We hope to publish proposed salary equivalency guidelines soon.

We have also enlisted the aid of physicians in curtailing the inappropriate practice of targeting a facility's entire patient population for the indiscriminate provision of therapy assessments and treatments en masse, without regard to whether each individual within the group has an actual medical need for the services. We have encouraged physicians

to resist pressure to order or approve any therapy services that are not, in fact, medically necessary to improve or maintain the individual resident's functional status.

We are also using the some of the funding provided through our Operation Restore Trust demonstration to compare all bills submitted for nursing home residents and to identify services billed under both Part A and Part B.

Payment Reform Legislative Proposals

Of course, control of post-acute care expenditure growth cannot be fully realized without legislation, and both the Administration and the Congress have appropriately made payment reform of the SNF and HHA benefits a top priority in Medicare reform. I will describe our payment reform proposals and will then compare them with the proposals that appeared in the Conference Agreement, where appropriate. There are important areas of common agreement and areas where our policies diverge. But I believe that we have an opportunity to strike common ground on a number of issues, and I assume that when the Administration and Congressional leaders get back to the budget negotiating table, the areas of common agreement will be critical to a successful budget compromise.

The Broader Context for Payment Reform: A Beneficiary-Centered Delivery System and, Perhaps, an Integrated Payment System

Before I delve into specific legislative proposals, I'd like to suggest that these proposals should be viewed as means to an end, not an end in themselves. Many argue that the post-acute care payment system of the future must be one that provides comparable incentives across delivery sites. While we should not stop our efforts to develop prospective payment systems for post-acute providers, we should not be permanently wedded to separate payment systems for each of the self-contained benefits. Rather, we should strive to better understand the value of each post-acute care provider type and how to better manage and coordinate care across the health care continuum.

I would suggest that payment reform should support an infrastructure of post-acute and long-term care delivery systems that is better integrated and more flexible in meeting the needs of those with chronic conditions and disabilities. That is, a guiding principle in any lasting reform of the Medicare post-acute care benefits should be to make the system of services "beneficiary-centered." To be beneficiary-centered, an integrated delivery system needs a reliable and predictable stream of financing. But, it also requires a system of maintaining information on clients that is consistent and available to all service providers. This kind of information is essential as we work to target funds and determine how we go about fairly and accurately assessing what kind of care someone needs. Beneficiary-centered services also rely on inter-disciplinary case management that involves formal and informal caregivers and supports and encourages, where appropriate, beneficiaries to direct their own care. Finally, a beneficiary-centered system needs relatively standardized service packages typically provided by various health care professionals.

There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. These distinctions are becoming increasingly blurred with advancing technology. For example, physical therapy and other rehabilitation services can be provided in each of the settings. A recent HCFA analysis shows that 53 percent of beneficiaries treated in the hospital for hip fracture use SNF services, 14 percent use home health services, and 14 percent use

rehabilitation hospital services. Similarly, 25 percent of patients treated in the hospital for stroke use SNF services, 26 percent use home health services, and 16 percent use rehabilitation hospital services. While there may be some clinical differences in the patients who go to each of these settings and in the outcomes as a result of care provided in each of these settings, it is also likely that patient and physician preferences influence which type of post-acute service is used.

Despite the considerable overlap, Medicare's payment and coverage rules vary by setting. While I don't wish to discount the importance of beneficiary preference in making these decisions, I would like to ensure that Medicare payment is not the primary reason for care setting decisions. Medicare payment methods and amounts for similar services provided in each of the post-acute settings differ. And more expensive stays do not always imply more services or better outcomes. For example, some provocative early research findings suggest that, for some conditions, outcomes may be no better for beneficiaries treated in one setting than another, even though Medicare payment may be substantially different. I am hopeful that further research into the characteristics of patients that use care in each of the post-acute settings, and an analysis of outcomes, can provide information about the most appropriate setting for different types of patients.

As I've suggested, any effort to control the utilization of post-acute care services and ensure equity and appropriateness of payment must involve a mechanism to track outcomes and services that address patient care needs. Such a mechanism ideally begins with a valid and reliable assessment screening instrument that would provide a preliminary assessment of the patient's needs and the types of services that would best meet desired health outcomes at the lowest possible cost. This type of instrument could also be used to assess the individual's values and preferences for continuing care, so that if two or more types of care would typically provide the desired outcomes at comparable costs, the individual could choose the type of care he or she would receive under Medicare. Such an assessment instrument should also be made up of core data elements (e.g., functional status, available care supports, etc.) that would be relevant across the care continuum and that would support case-mix payment systems.

As you may be aware, HCFA has been developing assessment instruments -- the Uniform Needs Assessment Instrument (UNAI), the long-term care facility minimum data set (MDS), and the Outcomes and Assessment Information Set (OASIS), which is a core standard assessment data set for home care. The next challenge is to identify common elements among the instruments to support an integrated payment system.

Additionally, HCFA is evaluating case-mix systems to support prospective payment reforms. The Multi-State Case-Mix and Quality demonstration for SNFs has used the MDS to classify long-term care patients according to the intensity of resource use. Additionally, we are embarking on research toward the development of a case-mix classification system for HHAs which utilizes selected OASIS items. Other work is being conducted to evaluate the feasibility of a case-mix payment system for rehabilitation hospitals.

Under a possible future payment scenario, we would want to provide payments sufficient to ensure that beneficiaries receive high quality care in the appropriate settings, and that any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues.

In an effort to make payment systems "site-neutral," we might also consider splitting apart payment of the "medical" services from the room and board services.

That way, payment for the "medical" services can be the same for similar patients regardless of whether they are delivered in the home or in a nursing facility. This would help address problems related to the institutional bias as well as clarify the allocation of responsibilities between Medicare and Medicaid.

This discussion addressed our general direction regarding the future of post-acute care payments. The message I mean to convey is that we are thinking more broadly about an integrated reimbursement system for post-acute care services even as we focus our attention on the reform proposals that are currently on the table. In the meantime, we are committed to developing prospective payment systems for SNF and HHA providers.

The prospective payment systems for SNFs and HHAs form the heart of our payment reform proposals in the President's Medicare balanced budget package. The development of PPS systems for SNFs and HHAs is proceeding well, despite delays. The delays have been largely due to the complexity in developing case-mix systems.

Status of PPS Demonstrations and Studies -- What We've Learned to Date

Home Health

The National Home Health Agency Prospective Payment Demonstration is testing two alternative methods of prospective payment. Phase I of the demonstration tested a per-visit prospective payment. Phase II of the demonstration, which began in June 1995, is testing a per-episode prospective payment, and will last for two more years.

In Phase I, we tested a per-visit payment method that established a separate payment rate for each of six types of home health visits (i.e., skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services). Although we found that agencies being reimbursed through prospective rates were more likely than other agencies to keep their cost increases below inflation, the differences were fairly small. The demonstration had no significant effect on the number of visits provided, quality of care, access to care, and other Medicare costs. Thus, we learned that a per visit payment methodology is not effective in controlling expenditure growth.

In Phase II, participating HHAs are receiving an agency-specific episode payment based on 120 days of care and outlier payments for episodes that extend beyond 120 days. Outlier visits are reimbursed at per-visit prospective rates. A new episode of care does not begin until there has been a gap in home health services for 45 or more days after the initial 120 days. Agencies receiving per-episode payments are subject to stop-loss and profit sharing provisions.

The episode rates are based on an agency's cost experience during a base year -- the year prior to the agency entering the demonstration. Thus, the per-episode rates used during the demonstration reflect an agency's case-mix during the base year period. In recognition that an agency's case-mix may change during the demonstration relative to the base year period, the demonstration includes a case-mix adjuster as one of its payment adjustments. If an agency serves patients requiring relatively few services during the base year period and then serves patients requiring more resources during a demonstration year, the per-episode payment rate may not be sufficient. The case-mix adjuster adjusts payments for differences in patient characteristics. It is designed only to refine payments to reflect case-mix change within an agency, not to differentiate case-mix among HHAs.

We do not yet have results from this phase of the demonstration. Thus, we do not yet know whether the definition of an episode chosen for the demonstration (120 days) is an appropriate definition for a national payment system. This is because 120 days captures only about 60 percent of all home health visits. If 120 days were to be used as an episode in a national payment system, that would mean that almost 40 percent of all home health visits would fall outside the episode as outliers.

SNFs

In July of 1995 we began our Multi-State Nursing Home Case Mix and Quality Demonstration. This three-year demonstration is testing a per diem prospective payment system and a quality monitoring system for SNFs. The payment system utilizes resident assessment data (the MDS 2.0) applied to resource utilization groupings (RUGs III) to determine case-mix adjusted payments. In the first year, only routine costs were paid prospectively. Recently, we have begun incorporating payment for therapy services furnished to Medicare beneficiaries into the prospective payment. Over 500 nursing homes are participating in the demonstration.

To date, the demonstration has provided valuable insight into the proper design of a PPS system for SNFs and informed us about how best to implement such a system. We're in the process of working out many of the operational issues to make a full scale implementation easier. We've also learned that subtleties in the elements that make up the case-mix adjustor can send strong signals to providers -- that making payment contingent on patients requiring services means that many more patients will receive those services. We've learned that it is appropriate to use the same assessment instrument for both Medicare and Medicaid. We've also learned that interrupted SNF stays may be more common than previously thought (for example, one-third of stroke patients are readmitted to the hospital under a different DRG); this greatly complicates the design of a per episode PPS.

Description of Administration's Proposals for Payment Reform

The information we have gained from the demonstrations thus far laid the foundation for the payment proposals that were included in the Presidents FY 1997 budget submission.

Home Health Payment Reform Proposals

We proposed a number of home health payment reforms designed to achieve needed cost control, improve financial management, and control fraud and abuse. The focus is our plan to transition into a per-episode PPS in 1999. There is broad agreement among industry representatives, and many members of Congress, that a per-episode payment system is the superior way to constrain costs without sacrificing access or quality. We have sketched out in our legislation some of the features that are desirable for such a system. For example, we would anticipate that all services currently covered and paid on a reasonable costs basis under the Medicare home health benefit, including medical supplies, would be covered under the payment. The per episode payment amount would be based on the most current audited cost report data available. We would employ an appropriate case-mix adjuster that explains a significant amount of the variation in cost. The episode payment amount would be adjusted annually by the HHA market basket index. The labor portion of the episode amount would be adjusted for geographic differences in labor-related costs based on the most current hospital wage index. The Secretary would have the authority to designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the

type or amount of medically necessary care. Finally, if a beneficiary elects to transfer to, or receive services from, another HHA within an episode period, the episode payment would be pro-rated between the HHAs.

We are committed to implementing a PPS system for home health as soon as possible. There is, however, some work remaining to be done before we can implement such a system -- namely, the development of a case-mix adjuster that can explain a significant amount of variation in costs per case and the development of an appropriate definition of an episode of care. Our legislation seeks authority to request data from HHAs to support our research and development efforts.

While we continue to develop these essential features of an episodic PPS system, we propose to implement an interim payment system that would allow us to achieve some cost control. The Administration's interim payment system would rely on proven techniques of current law in an effort to achieve guaranteed, up-front savings without disrupting the industry with a host of new payment methods.

The interim system would superimpose a new cost limit onto the existing cost-based reimbursement scheme. This new cost limit would build on agencies' actual experience (in a base year) in resource use per beneficiary. It would give agencies the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of caregiver) within this limit, and to share in savings if agency costs fall below this limit.

To be more specific, payment to an HHA would be the lesser of: (1) the agency's actual costs, or (2) a per visit cost limit set at 105 percent of the median national cost for free-standing HHAs, or (3) this new agency-specific per beneficiary annual limit. As soon as feasible, we would modify the agency-specific per beneficiary limit to reflect regional or national variations in utilization. This proposal can be implemented immediately, with few administrative changes at negligible cost, and allow for a sensible phase-in to a prospective payment system.

We also proposed to eliminate periodic interim payments (PIP) for home health agencies simultaneous with PPS implementation in 1999. PIP was established to encourage new providers to participate in Medicare by improving cash flow by paying a set amount on a bi-weekly basis. However, with about 100 new HHAs joining Medicare each month, access to home health is no longer a problem. Further, the Office of the Inspector General has found that Medicare tends to overpay providers who receive PIP, and has validated our contention that it is sometimes difficult to recover these overpayments.

We also proposed to base the visit payment limitation on the location where services are rendered, not where services are billed. Many HHAs are established with a parent office in an urban area and branches in rural areas. When HHAs bill Medicare, the payment limitation is based on the higher wage rate for the urban area even though the service delivery occurred in a rural area.

In comparison, the Conference Agreement proposal called for the immediate implementation of a prospective payment system for home health. Agencies would be paid a per visit prospective rate subject to an annual dollar cap that would be calculated to approximate all covered service delivered to a beneficiary during a period of 120 days. However, the payment cap would be implemented such that HHAs would be paid for providing 165 days worth of services with 120 days worth of dollars. Agencies that keep total payments for the year below the annual cap would be allowed

to retain 50 percent of the savings. Numerous outliers and extended care exceptions would be paid outside of the cap on a per visit rate.

The Administration opposes the Conference Agreement proposal for the following reasons. First, we believe that savings cannot be guaranteed since the proposal relies wholly on an untested, unreliable new payment methodology that uses an inappropriate case-mix adjuster and that would allow about 30 percent of visits -- outliers -- to be paid a prospective rate subject to no utilization control. To the extent that savings do not reach the savings target, the Republican failsafe hammer would have come down hard on agencies.

Second, we fear that the proposal to pay 165 days of service with 120 days worth of dollars creates an incentive for agencies to avoid caring for heavy care and long-term care patients and thus would hurt access to, and continuity of care for, the sickest patients with the greatest needs.

Third, the plan is built upon the false assumption that data and systems are in place to facilitate immediate implementation. In fact, we are certain that it would take 2-3 years to develop the systems and gather the data necessary to implement the payment scheme.

Fourth, the Conference Agreement prescribes "policing" of the industry by HCFA to ensure that agencies do not circumvent the system. This policing would add significant additional administrative expense to HCFA and be very burdensome to the industry.

Finally, the Conference Agreement does not provide for an eventual transition to a comprehensive PPS that covers all HHA visits.

We understand that the home health industry has put forth a new proposal that may have gained some attention by lawmakers. This proposal would impose two interim reimbursement systems upon the industry until an episodic PPS can be introduced. The second phase is similar to the Conference Agreement and the concerns we had about that proposal are comparable. The first phase would entail a per visit PPS. Frankly, we have to do some more study on this new variant, but we continue to believe that our proposal is superior to the other proposals.

I know you are aware of our proposal to shift financing of a portion of the home health benefit from Part A to Part B. Under our proposal, the first 100 home health visits following a three-day hospital stay would be reimbursed under Medicare Part A. All other visits, including those not following a hospitalization, would be reimbursed under Part B. Part B visits would not be subject to the Part B coinsurance or deductible. The transfer would not affect the Part B premium. The proposal would not alter general coverage or eligibility rules and thus would have no change on access to the benefit by beneficiaries.

Clearly, by capping Part A financing of the home health benefit, we would be saving the financially vulnerable HI Trust Fund about 55 billion dollars over 7 years. This is an important motive, and I note that Republican members once intended to achieve the same goal with a similar technique. But there are other sound reasons for this policy and, to explain them, I need to put this proposal into some historical context.

As I've already discussed, the home health benefit, like the SNF benefit, was

originally designed to provide short-term, recuperative, post-acute care services to beneficiaries after discharge from a hospital. The benefit was only available to those beneficiaries who were discharged from a hospital following a minimum 3-day stay. The benefit provided up to 200 home health visits during a calendar year. The first 100 visits were financed under Part A of Medicare. There was no beneficiary cost-sharing during these visits. If beneficiaries exhausted all of these Part A visits and carried Part B insurance, they were then eligible to receive additional visits financed under Part B, up to a maximum of 100 visits. For these visits, beneficiaries bore some of the costs through a $60 deductible. (Until 1973, beneficiaries also paid coinsurance for Part B visits).

In Congress' view, the pre-OBRA-1980 home health benefit was too limited, resulting in some beneficiaries using too much expensive institutional care. For this reason, in OBRA-1980, Congress removed the Part A and Part B visit limits and eliminated the hospital stay requirement. Home health thus became an unlimited benefit.

An unintended consequence of the OBRA-1980 change was to burden the Part A Trust Fund with approximately 99 percent of the financing for the home health benefit, regardless of whether or not visits are related to a hospital stay. The huge shift in financing to Part A clearly was not consistent with the original intent of Part A, the Hospital Insurance Trust Fund, which was designed to only finance services that centered around a hospitalization.

The President's proposal to move a portion of the financing of home health back to Part B restores the original Part A coverage of post-hospital services and allows Part B to finance all other home health services. It maintains Congressional intent for a home health benefit that is available to all beneficiaries regardless of their Part A and Part B coverage. And it maintains Congressional intent to have a home health benefit that does not require out-of-pocket expenses borne by beneficiaries. Finally, it will allow us to better focus coverage policies for the two groups of home health users -- post-hospital and chronic care users.

Let me end the home health discussion with a note of agreement. Both the Congress and the Administration wisely proposed to permanently extend the savings from the OBRA-1993 freeze on home health cost limits by not allowing for the inflation that occurred during the freeze. In the absence of this legislation, spending reverts to pre-freeze levels. Also, both the Congress and the Administration agreed that the home health re-certification survey frequency should be lessened in certain cases in order to allow the Secretary greater flexibility in targeting resources toward poor performing HHAs and to give relief to the current backlog of initial certification surveys. This change became law when Congress passed our FY 1996 appropriations and we thank you for the relief it provides.

SNF Payment Reform Proposals

As with home health, both the Administration and the Congress agree that the savings of the OBRA-1993 cost limit freeze should be permanently extended for SNFs.

With respect to SNF reimbursement reform, we are further along with our research and demonstration efforts on SNF PPS and thus could implement a system more quickly than in the case of home health. However, as with home health, we have a two-stage proposal to allow us to transition to a fully prospective PPS for SNFs.

We have a multi-part proposal for our interim system. First, we would establish an interim prospective rate for routine costs. This rate would be based on facility-specific costs, subject to regional limits. The regional limits would be based on data from freestanding SNFs only. Under current law, hospital-based SNFs are allowed a higher cost limit to reflect the higher costs in these SNFs. However, research has not substantiated a difference in the characteristics of patients treated in hospital-based and free-standing SNFs.

Second, we propose to eliminate immediately the new provider exemptions and new exceptions to the cost limits. The 3-4 year cost limit exemption for new providers under current law allows SNFs to be reimbursed for inflated costs for several years. Meanwhile, the exceptions for atypical care or extraordinary circumstances effectively allow SNFs to bill Medicare fully for more costly "sub-acute" care services which Medicare reimbursement would not otherwise completely cover. Under our proposal, SNFs that had exceptions in the base year would be protected under a hold harmless provision.

Third, we would require SNFs to bill Medicare for all services their residents receive (except the services of physicians, certified nurse midwives, psychologists, hospice services, and nurse anesthetists), prohibiting payment to any entity other than the SNF for services or supplies furnished to Medicare-covered SNF patients. This consolidated billing proposal is offered, in part, in response to Inspector General reports that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. It would also reduce beneficiary Part B copayments for services covered under Part A. To ensure that Medicare doesn't overpay for these services, we would also establish limits on ancillary services based on amounts payable for similar services provided on a fee-for-service basis under Part B. In order to implement this, we would require SNFs to include HCFA Common Procedure Codes on their bills. This would also provide the data necessary to construct a SNF PPS rate that covers ancillary services.

As an additional control on ancillary expenditure growth, we also propose to update the therapy guidelines for physical therapy (PT) and respiratory therapy (RT), and establish similar therapy guidelines for occupational therapy (OT) and speech-language pathology. As part of their SNF care, Medicare beneficiaries are eligible for therapy services. While some SNFs employ their own therapists, many use contractors to provide these services. Salary equivalency guidelines determine the maximum Medicare payment for the service, based upon an estimate of the costs of providing the service via a salaried employee. We discussed this effort under our administrative efforts to control costs. Because of the time consuming process we must go through to accomplish this administratively, we are also proposing legislation to accomplish this more quickly.

We are committed to implementing a full PPS beginning in FY 1998, and our proposed legislation reflects this commitment. The prospective rate would be designed to cover all three SNF cost categories -- routine, ancillary, and capital-related costs.

The Conference Agreement also proposed an interim and full prospective payment systems. The interim payment system would remain cost-based. Routine costs would be subject to the current limits which are separately computed for hospital-based and freestanding SNFs. However, the definition of routine costs would be expanded to include additional services. Ancillary services would be subject to a per episode limit. Capital payments would be reduced by 15 percent.

One area of difference between the Congressional and Administration provisions is the unit of payment for the prospective payment systems. The Administration's plan does not specify whether PPS payments should be made on a per episode basis, as in the Republican plan, or on a per diem basis. We have decided not to specify a unit of payment until further research and demonstration results can shed light on the appropriateness of one or the other. We are concerned that the Conference Agreement provision is based on a system that has not been appropriately informed by research. HCFA has been testing a per diem prospective payment on a demonstration basis in six States, and States have been implementing per diem prospective payment systems for years. There is no comparable information for per episode payment system. Not only do we not have sufficient information to determine the appropriate level of payment, no research has been conducted on the effects of a per-episode payment system on patient outcomes, quality, or access to care.

The incentive under a per episode prospective payment system could be for facilities to discharge patients as quickly as possible as facilities receive the same payment irrespective of how many days the beneficiary remains in the SNF. Earlier discharge may result in poor quality care and increased overall program costs as beneficiaries still needing services may return to the hospital or initiate home health visits. Furthermore, in the absence of an accurate case-mix adjuster (which currently does not exist to predict per-episode costs), SNFs would have an incentive to avoid more resource intensive patients and access to SNF care for the beneficiaries that need it the most would be reduced.

Another area of significant disagreement is the Conference Agreement's provision to place limits on ancillary (non-routine) payments. We are concerned that these limits could place patients at risk of receiving inadequate services. Facilities would have the incentive to ensure that the cost of services their patients receive does not exceed the limit, since they would receive no additional reimbursement for any additional services. The Administration's proposal would provide controls on expenditures for ancillary services by requiring facilities to bill for the services its patients receive, establishing therapy guidelines, and limiting payment of other ancillary services to the Part B fee schedule, without placing beneficiaries at risk of receiving inadequate services.

Finally, the Conference Agreement would also fail to eliminate the differential in payments between freestanding and hospital-based SNFs. Research has revealed no significant differences between patients in freestanding versus hospital-based SNFs and provided no justification for the payment differential. The Administration's plan recognizes that this distinction is no longer justified and would apply the same cost limits to hospital-based and freestanding SNFs.

Conclusion

There is widespread agreement that SNF and HHA expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that legislative efforts are needed to slow down this growth. I have laid out for you today our vision for the future of post-acute care payment. Because we do not yet have all the tools to implement this vision, this Administration has put forth concrete proposals to modify payment policies for SNFs and HHAs, and I have described these for you today. There are significant differences between the payment proposals put forth by the Administration and by Congress. However, there are many commonalities. It is my hope that we can work together to develop payment policies that provide the right incentives -- incentives to provide quality care, promote access to care, and inhibit fraud and abuse. Thank you for the opportunity to testify today.

Chairman THOMAS. Thank you, Bruce. This is becoming a weekly scenario. I know that it is difficult for you to do all your other work that you are charged with doing, and we appreciate the willingness not only to come and testify but to spend some time answering questions and interacting in a way that we better understand what you are doing. It is an imposition on your time, and we know that.

I want to visit a couple of points. I have a whole bunch of questions. I will probably have to submit a number of them in writing rather than taking all afternoon, as we have done before. You do mention in your testimony the administration's proposal in transferring, following a certain profile, home health care costs from part A to part B. It has usually been described as a $55 billion savings to the HI Trust Fund. Is that your number or CBO's number?

Mr. VLADECK. I believe that is the OMB/President's budget estimate number.

Chairman THOMAS. You believe it is the OMB number? I believe——

Mr. VLADECK. I am sorry. That is the CBO number.

Chairman THOMAS. I believe it is the CBO number.

Mr. VLADECK. OK. Yes.

Chairman THOMAS. Do you have a number that was generated by OMB that either agreed with or differed from the CBO? My assumption is, if it was higher, you took the CBO one.

Mr. VLADECK. We did have a number, Mr. Chairman. I honestly do not remember what it was. I would be happy to give that to the Committee as soon as I——

[The following was subsequently received:]

The estimate generated by OMB for the proposal to transfer certain home health costs from part A to part B was $69.55 billion through 2002, using the fiscal year 1997 budget baseline. This amounted to approximately 54 percent of home health costs and was based on the most recent data available at that time. This estimate is higher than the CBO estimate because CBO, we believe, transferred 40 percent of home health costs to part B. (This was based on the latest available to CBO on the proportion of home health visits above 100.)

Chairman THOMAS. Here is my reason for asking that question; because I recall when the trustees presented the Trustees' Report, there was a major press conference, and Secretary Shalala indicated that one of the reasons they were in support of this was that we were returning to the pre-1980 structure. I took some objection to that because it was not returning to the pre-1980, and we had testimony to indicate that. In fact, you folks agreed, because it did not include the deductibles that were available back then, so it was—arguably, the concept was the same, but the mechanics and the payment structure were different.

What I do not think everybody has appreciated—and I want to make sure I understand the trigger mechanism that you have, because I think CBO may have misunderstood the trigger mechanism as well. You say that the part A costs for home health will remain in part A if it follows a hospital visit and the number of visits is less than 100.

Mr. VLADECK. That is correct.

Chairman THOMAS. Is there any time consideration from the time the beneficiary was in the hospital and the first of the 100 visits was triggered?

Mr. VLADECK. We used the Medicare term of art of a spell of illness, so it would need to be associated with the same illness for which the hospitalization occurred.

Chairman THOMAS. And the spell of illness is defined by time or condition?

Mr. VLADECK. It is defined by condition and the receipt of services. In other words, if one has a spell of illness for pneumonia with a set of pneumonia-related services and then goes 30 days without the receipt of any services associated with that illness, that defines the end of the spell of illness.

Chairman THOMAS. So, it has a time as well as a condition definition. My understanding is the 3-day hospital is the minimum trigger for the benefit, and 100 is the maximum number of visits under part A. But you have introduced another factor, which I do not think CBO fully appreciated, and that is the 30-day trigger.

Mr. VLADECK. I would have to make inquiry, but I would be happy to.

[The following was subsequently received:]

The Medicare statute defines a "spell of illness" as beginning on the first day a beneficiary receives inpatient hospital services, inpatient rural primary care hospital services, or extended care facility services and ending on the first period of 60 days in which the beneficiary is not an inpatient of a hospital, rural primary care hospital, or SNF. Under the administration's home health transfer proposal, Medicare part A would cover up to 100 home health visits during any spell of illness if the services were furnished in accordance with a treatment plan developed during a stay of no less than 3 days in a hospital or rural primary care hospital and home health services began within 30 days of discharge. There is no "condition" definition, as you have described it. Also, Medicare part A would cover home health services furnished to a beneficiary who has part A coverage only.

All other home health visits, including those not following hospitalization, would be reimbursed under part B and not be subject to the normal part B coinsurance or deductible. Furthermore, this proposal would not affect the part B premium.

Chairman THOMAS. So, how do you get to part B under your plan? The shift from part A to part B, regardless of whether it is generally defined as chronic or acute, would occur after 100 visits or the first visit after 30 days.

Mr. VLADECK. Or, the first visit for a patient who has not been hospitalized for the condition for which the home health services are provided within the preceding 3 days.

Chairman THOMAS. And if the patient has been hospitalized, meets the 3-day minimum, but does not start that first visit until more than 30 days after discharge, that goes to part B?

Mr. VLADECK. I believe we would define that as a separate spell of illness, yes.

Chairman THOMAS. My belief is that OMB did not compute that. They computed it on a weighted average from the 100 and more than 100 normal shift. You will find that if OMB computed the actual dollar shift based upon our understanding of the President's policy, it would be significantly higher than $55 billion. And, I am going to request OMB to rethink the way in which they designated the costs, because it is, again, far higher than the $55 billion. If you have any information or data that OMB or others did—I keep saying OMB. I mean CBO, obviously.

The Congressional Budget Office, I believe, in computing their numbers did not fully appreciate the time factor. If you folks did in your policy and you came up with different numbers, or you did

and you believe you can substantiate what CBO did with its numbers, the Chair would very much appreciate the clarification on that, because I do think we are going to get a discrepancy in the numbers.

Mr. VLADECK. We will look into it, sir.

[The following was subsequently received:]

I believe you are correct. It is our understanding that the CBO assumed that Medicare part B would cover all home health visits over 100 without regard to whether or not there was a hospital stay.

Chairman THOMAS. In dealing with home health, you talked about areas that you are trying to deal with in terms of case mix adjuster and the variation in costs per case and the development of an appropriate definition of an episode of care. Obviously, this has been going on for some time.

Do you want to go out on that limb? When can we get some kind of a yardstick, or are we probably pursuing the wrong approach to trying to measure? Where are we?

Mr. VLADECK. We believe, Mr. Chairman, we can begin field testing new classification systems or measurement systems for home care case mix during 1997. To have a full year of data on the case-mix experience of home care agencies applying these new techniques would take us into calendar 1998. We will be in active testing of such classifications within months from now, not years from now.

Chairman THOMAS. And, you indicated that perhaps you may be seeking some legislative authority to get some data that you cannot now utilize to help those research efforts. What is it that you do not think you can do? What do you need from us, and why?

Mr. VLADECK. Well, let me tell you what is perhaps the most significant part of that, and it has to do with some issues in the definition of eligibility for home care services. But we have found in development of nursing home case-mix measures and in much of our other long-term care activity that the functional status of the patient—their ability to perform activities of daily living—is often a more powerful predictor of how much service they will need than a medical diagnosis.

We do not routinely collect systematic data from home health agencies on activities of daily living. The data we get from home health agencies at the moment is very much tied to a so-called classical medical model. It identifies particular problems for which skilled services are required but does not give us a complete enough picture of the characteristics of the patient to develop the information we need on case-mix characteristics.

Chairman THOMAS. Finally, for this round, you indicated that you agreed with us in terms of not building into an updated cost limit freeze period. But my belief is that you did build in an increase for that period by including an inflation factor. Is that correct? Notwithstanding the fact that they were frozen, you provided for an inflator. Can I go back to early math where they kept telling me that one times zero is zero, two times zero is zero, three times zero is zero, and so forth? So, I do not understand how you can include an inflating factor when the base was zero.

So, one, is it true that you included an inflation factor for those years that we had the freeze, notwithstanding the fact that you included the freeze?

Mr. VLADECK. My understanding is that the proposals and the associated pricing in both this year's President's budget proposal and last year's took the freeze through the end of 1996 as a given. We began inflation from the expiration of the OBRA 1993 freeze and rolled that forward into the prospective payment systems, but did not go back into the freeze period and reinflate.

Chairman THOMAS. So, you believe you did not include inflation for the period that we had the freeze.

Mr. VLADECK. That is correct. I believe that was what we intended to do. I qualify that only because I think we kept the proposals in separate parts of the legislation, and I believe the scoring reflects that. I will double-check that, but I am pretty sure that is what——

[The following was subsequently received:]

OBRA 1993 mandated a freeze on Skilled Nursing Facility (SNF) routine cost limits and Home Health Agency (HHA) cost limits for 2 years. The freeze on SNF routine cost limits expired on September 30, 1995; the freeze on HHA cost limits expired on June 30, 1996. the Medicare statute requires that both SNF and HHA cost limits be updated, in a prescribed manner, for the postfreeze periods.

The SNF routine cost limits effective for cost reporting periods prior to the OBRA 1993 freeze were extended through the freeze. The inflation that would have been added in each of those two years was not paid, and this resulted in savings to the Medicare Program. However, by law, HCFA must recognize the inflation for the 2 freeze years (fiscal years 1994 and 1995) in determining the fiscal year 1996 limits. As authorized by section 1888(a) of the statute, we updated the limits by inflating the previously issued schedule of cost limits, rather than by rebasing the cost limits using the most recent available cost report data.

For the most recently published HHA cost limits, we updated for the freeze years through a rebasing of the cost limits using the most recently available cost report data. This manner of inflation adjustment is prescribed by section 1861(v)(1)(L)(iii) of the Medicare statute.

As you are aware, both the Congress and the administration had proposed to permanently capture the savings generated by the OBRA 1993 freeze on SNF and HHA cost limits. Our proposal would not have extended the freeze, but instead would have permanently extended the savings realized from setting future cost limits in a manner that would not allow for the inflation that occurred during the freeze. Now that the OBRA 1993 freeze has expired for both SNFs and HHAs, and HCFA has had to accommodate inflationary increases in the latest schedules of cost limits, the Congress and administration may want to consider other mechanisms by which we can permanently capture the savings generated by the freeze.

Chairman THOMAS. You believe it was your intention to do that, notwithstanding the fact it may not have been done; or it was done, and it was your intention?

Mr. VLADECK. Well, it was done, I believe, in the legislation. The problem is that we have since been required by law to update the cost limits for both SNF and home health agencies, effective this past July 1, because the OBRA 1993 limits expired without intervening legislation.

Chairman THOMAS. That may be an interpretation of the law. We may interpret it differently.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

Just a couple things. Your Inspector General last year, I think, found that there was a higher reimbursement in home health agencies that are proprietary and recommended that we not grandfather in the utilization patterns of higher reimbursing agencies. Is

this something that you plan to do, or do you think that the proprietaries are providing better care since they do more visits?

Mr. VLADECK. Well, one of the concerns we had about the conference agreement proposal was the notion of moving to an interim prospective payment for home health agencies based on individual agencies' experience in terms of case-mix adjustment. And, we do not think we should use a case-mix-based system for home health agencies until we have one that does not depend on agency-specific data and accurately explains variations in costs across different kinds of agencies in different parts of the country.

So, with the development of the right kind of case-mix classification for home health we are seeking one that would not be affected by either differences in prior practices among agencies or by different modes of operation prospectively for the agency.

Mr. STARK. I am not sure we are talking about the same thing. I am just talking about the higher costs due to higher utilization patterns. I do not know whether that has anything to do with case mix. Your inspector general found that you just had utilization patterns that were higher in the for-profit agencies. Is that——

Mr. VLADECK. The question is, as always——

Mr. STARK. Nothing with regard to case mix. I am just talking about patterns across a group. In fact, is that something you want to grandfather in?

Mr. VLADECK. No, it is not, which is why I think we need an agency-neutral measure of case mix eventually.

Mr. STARK. Let's hop to the end. Can we have one PPS for all post-acute services?

Mr. VLADECK. We would like eventually to move in that direction.

Mr. STARK. All the way to bundling?

Mr. VLADECK. I am not sure about that. Let me distinguish between the two, if I could.

Mr. STARK. OK.

Mr. VLADECK. We have stumbled into a recognition that we have invested a lot of time and energy in the development of separate patient assessment systems and forms and processes for nursing home patients, for home health agency patients, for patients in hospitals awaiting discharge, and in many Medicaid Programs, for recipients of home- and community-based long-term care systems.

All of these forms or assessment devices have enormous amounts of overlap across the different kinds of services. We have also known for a very long time that there is an enormous amount of substitutability between the kinds of services people who receive home care get, those in nursing homes get, those in hospital-based long-term care facilities get, and so forth. We also know that the actual service a person receives is as much a function of what is available in the community, what the physician is familiar with, and what the individual's preference may be, as any clinical or scientific determination.

Mr. STARK. You did not factor in one other thing. What leads to the highest gross payment if, in fact, the hospital owns the home health agency, shortens the DRG, diagnosis related group, stay, collects the full DRG, and then collects out of the home health

care? It is getting more per patient, right, than when it is separated?

Mr. VLADECK. That may also be a consideration.

Mr. STARK. You think that might be a factor.

Mr. VLADECK. The point is if a patient needs 2 hours a day of skilled nursing services and some housekeeping and some physical therapy three times a week, whether they receive it in a SNF or a subacute unit of a general hospital or a rehab hospital, for the great bulk of patients it may very well be the same identifiable bundles of service.

If we can really predict the appropriate bundles of service based on patient characteristics and put a price on those, then that should not vary by site of service. And the payment system should be the same for all like services, regardless of where the patient receives them.

Then the question becomes, how do you distinguish payment for residential facilities where there are hotel costs or room and board costs from services delivered in the home? That also gets to some very interesting Medicare/Medicaid interactions. But in the long term, if we want a system that is driven by patient characteristics connecting to a set of services the patient ought to get, the exact place where this patient receives those services may not matter. We are a little ways from being able to demonstrate that.

Mr. STARK. Thank you.

Chairman THOMAS. I thank the gentleman.

The gentleman from Nevada has a time problem, and if he would like to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

Mr. Vladeck, I just have a couple of questions. I know this is a little bit off the subject, but I think our office was in contact with yours this morning, and I just wanted to discuss the S/HMO 2s.

You were here on April 18, and we talked about it. I know you are a big fan of the S/HMO 2s and the demonstration projects that we have. We talked about the July 1 waiver date, and I personally talked to your office back in June, and I guess there were some problems held up. The problem was not with your office at that point. It was with OMB.

The company Sierra Health Services has now put in about $1.2 million to develop this program. They are very excited about it, and they have had to recently lay off 11 employees because of the delays. But your office talked to me at that time, which I relayed back to them, that August 1 still looked very good.

I guess what I want to find out is: Is August 1 going to happen? If not, what are the problems? And, how can we get it resolved?

Mr. VLADECK. August 1 is getting closer every day. It is a week from Thursday. I think that is still possible. We have talked to OMB about this within the last week. They are trying to move it as quickly as they can in the midst of their other work. If it is not then, I am confident it will be very, very soon thereafter. And we are doing everything we can to——

Mr. ENSIGN. The problem is your office told me that if it is like August 2, that puts everything off until September 1. In other words, if it is not by the 1st of the month, it puts everything off 30 days.

Mr. VLADECK. Yes, we have done the pricing and other work on a monthly basis, but we will, if we do not hit August 1, revisit that and see if, at the worst, we can make it the 10th or the 15th or some appropriately round number.

Mr. ENSIGN. Can I just get you on record to say you will personally do everything you can——

Mr. VLADECK. I will personally do everything I can, first, to see that we can hit August 1, or if the approval comes through shortly after August 1, to find a way not to require that they wait until September 1, to get up and running.

Mr. ENSIGN. Thank you very much, and thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Vladeck, let me just raise one point. I noticed in your testimony that you indicate you need legislative authority to request data from the home health agencies to support the research and development efforts in order to complete the necessary work to implement the new system. It is highly unlikely we are going to get a Medicare bill enacted into law this year. There are only a few weeks left of legislative calendar in order to get a bill passed.

I am wondering whether the administration would support a separate bill on this issue, and perhaps the leadership in Congress would also make arrangements that this type of legislation could be considered, so that we at least remove that obstacle in moving forward in this area.

Mr. VLADECK. We would be happy to work with the members to do such a piece of targeted legislation.

Mr. CARDIN. I would hope the Chairman would take note of that. If we are not able to get a major Medicare bill passed this year, we should at least try to pull out issues that are not controversial so that HCFA can at least get the type of information it needs from the provider groups in order to move forward. We might want to take a look at that to see whether we can at least get that aspect——

Chairman THOMAS. I would tell the gentleman that all the changes we made we thought were noncontroversial. Once we sit down and begin discussing what is and what is not noncontroversial, I hope there is something left on——

Mr. CARDIN. Well, it seems to me that getting information from the industry in order to implement the plan would be considered noncontroversial by everybody on this Committee, not just one side of the Committee. But anyway, I think it is worth it for us to try to isolate those areas just in the unlikely event we are not able to pass a comprehensive Medicare reform bill this year. But at least be able to move forward so that next year we are not in the same position in an area where there really is no controversy. Just a friendly suggestion from one Member of the Committee.

Chairman THOMAS. The Chairman is always open to friendly suggestions and thanks the gentleman. By the way, how are you coming with HCFA in Baltimore——

Mr. CARDIN. Oh, we are making——

Chairman THOMAS. Excuse me. I did not want——

Mr. CARDIN. We are making great progress, depending upon how you look at it.

Mr. Vladeck, on the waiver of liability issue that expired on December 31, 1995, I am curious as to what impact that has had on the number of denials and appeals. Some of us have looked at that waiver of liability issue with the SNFs and with the home health care industry as a way of reducing administrative costs for HCFA and unnecessary expenses by the provider groups, and I am curious as to whether you have seen an increase in the number of denials and appeals since the expiration of the waiver of liability provision.

Mr. VLADECK. Frankly, Mr. Cardin, I have not looked systematically at the data. It is a little early, but I should have and have not yet. We will report that to you in the next week or so.

My perception is that in the home health area we have focused so much of our review activities on a relatively small fraction of agencies which have anomalous billing patterns that the number of denials for most agencies has probably remained at the very low level. But, I do not want to say much more about that in the absence of actual data. We will supply it to the Committee and to you as soon as we can.

Mr. CARDIN. If you could get that information to me, I would appreciate it.

[The following was subsequently received:]

The limitation on liability protection for providers, suppliers, and beneficiaries (established under section 1879 of the Medicare statute) has not expired. Only the time-limited favorable presumption—in which HHAs, SNFs, and hospices were automatically reimbursed for noncovered services—expired on December 31, 1995. Therefore, under current law, providers may seek Medicare reimbursement on a post-denial basis if they experienced a denial that could not have been anticipated.

HCFA's inventory of claim denial statistics include both denied claims that are nevertheless paid under the limitation on liability protection and denied claims not paid under this waiver. We do not expect, and have not yet witnessed, any significant change in the overall denial rate resulting from the December 31, 1995, sunset of the favorable presumption provision, there has been a decrease in the percentage of claims, subject to the provision, that are ultimately paid.

Did HCFA undertake any cost/benefit analysis when you decided not to support the extension of the waiver authority?

Mr. VLADECK. I do not believe we formally had it scored. We did have some concerns expressed by the folks we work with on program integrity, both within HCFA and in the inspector general, around the issue. And there is always some concern about how you appropriately evaluate the savings associated with averted expenditures of that kind, most of our problems with home health agencies that are receiving periodic interim payments involve recovery of overpayments. If we had an agency where there was a waiver of liability, we paid them, then we found a pattern that justified removal of the waiver, we would be seeking to go after money that had already been paid. Even if we said we paid you $1 million too much, we might never recoup $1 million.

So, the cost/benefit on those issues is a fuzzy analysis. It was not formally scored.

Mr. CARDIN. Well, good. It has been almost a year since the expiration of the authority.

What I would also like, if you can get back to me, is whether it has had any chilling effect on the provider taking a marginal patient whose condition may not be fully known because they are

worried about the liability issues; whereas, under the former provisions, as long as they stayed in the comfort level, they did not have to worry about that. I am curious as to whether you have had any concern as to whether certain types of patients are perhaps being denied the ability to find adequate providers under the current situation.

Mr. VLADECK. We have heard that expressed prospectively as a concern on the part of some of the agencies. We have heard a very occasional anecdote about that. It will be a while before we can say anything systematically, but I would also suggest that some of the folks who are directly in the business could probably respond more directly to that. We will massage what data we can and see what we can provide you with at this stage in the process.

[The following was subsequently received:]

In our view, there is currently an oversupply of home health agencies and we do not believe that the current market conditions would preclude any beneficiary who meets our coverage requirements from receiving the providers' services. This is particularly so since there are long-standing administrative procedures which permit a home health agency that may have strong doubts to share the risk with the beneficiary.

In those few instances where an agency may have a strong doubt about Medicare coverage, there are billing instructions that permit the agency to inform the patient that it doubts Medicare will pay and then, if the patient chooses to receive the services, to bill Medicare and receive an official claims determination. In such situations, either Medicare ultimately covers the services or, if the services are not covered, the home health agency may bill the patient. In our view, these advance notice procedures protect the HHA from liability in situations where there is genuine doubt.

Mr. CARDIN. Thank you very much.

Chairman THOMAS. Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

I have a couple of questions. Before I ask those, though, I want to refer to your conclusion in your testimony, Mr. Vladeck, in which you say, "There is widespread agreement that SNF and HHA expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that legislative efforts are needed to slow down this growth."

I notice you did not say it is time to cut Medicare. It is time to slow down the rate of growth in expenditures in Medicare. I point that out simply to point up the fact that that is what we are all endeavoring to do, is slow the growth in expenditures in Medicare. It is not helpful to the effort, which we all have admitted on numerous occasions, that it is very difficult for certain parties—individuals, not political—to use this issue and say that one side or the other is trying to cut Medicare, when, in fact, we have all, from the First Lady to the Administrator of HCFA, said we are trying to restrain the growth, we are trying to slow down the rate of growth. So, I am glad you used that terminology in your testimony. I think it is accurate and it is helpful for us all to use that terminology and not stoop to the low political trick of saying that we are trying to cut Medicare when it would be better if we would all work together to try to slow the rate of growth.

Now, to my questions. There has been a growth in ancillary services related to SNFs, and I am just wondering, has there been a

study of whether there has been enhanced patient outcomes due to the growth of these ancillary services?

Mr. VLADECK. I do not know of any systematic study we could point to. I would acknowledge, implicit with your question, that much of the growth in ancillary services came after changes in the law in 1987. These changes were meant to encourage the provision of more extensive services, particularly the part A covered services, through arrangements between facilities and independent providers of therapies or other kinds of care.

So, to the extent that the growth has been in response to that desire, there probably has been an improvement in quality. However, we are concerned and we have some limited empirical evidence that the separate billing of ancillary services does not represent an increase in the number of services provided to patients. It just represents the unbundling of a billing process in which in the past we or the family or Medicaid paid an all-inclusive rate that included certain supplies, that may have included x rays, that included therapeutic services, for which we are now being billed separately. So, we do not have historical data from which we can tell the extent to which the increased billing is actually the result of the increased provision of services.

Mr. MCCRERY. Well, related to that, have you studied managed care's experience with post-acute services, either as it relates to Medicare HMOs or private HMOs?

Mr. VLADECK. We have one relatively good but small-scale study of managed care utilization of home health services in the Medicare Program. We do not have comparable data on skilled nursing facility care.

I must say the study of home care was rather discouraging in the sense that it suggested that some managed care firms might be under-supplying needed home health services to Medicare beneficiaries, counter to the probable over supply of certain of those services on the fee-for-service side. But it is a one-shot, one-time kind of study, the most systematic data we have, and we do not have comparable data for SNF services.

Mr. MCCRERY. Any plans to expand our knowledge on that?

Mr. VLADECK. Well, we believe the the case-mix demonstration, which we are currently conducting in six states should give us data on a number of clients who are managed care enrollees as well as the full array of services they are receiving in those facilities.

Mr. MCCRERY. Thank you.

Chairman THOMAS. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

When the Medicare legislation was written, a fatal error was made when they included the usual and customary fee language for physicians. I am looking for the same kind of mistake in the way the language was written with respect to the home health care benefit. Do you think there is specific discrete language that needs to be changed? I understand that obviously there are many factors that have gone into the increase in home health care spending. The increase is partly moving people out of hospital beds more quickly into ambulatory settings and so forth. But once having done that, said that, and factored that part out of the increased spending, I

would be interested in hearing your suggestions about the kinds of things that you would do if you had a free hand and could redesign the program now knowing what we know.

Also, I have the feeling that from some of the managed care operations—I know from Group Health of Washington that they obviously are doing this as a part of their whole managed care approach, but most managed care operations do not collect data in a way that HCFA can access it and decide how much spending is from overutilization and how much is not. And so, I do not know where you can get the data to make a judgment about the bundling of services.

I am really giving you kind of a blue book question because I really do not have a clear idea how to go with this issue.

Mr. VLADECK. My own focus of effort in the basic statute would be the definition of coverage for Medicare home care services. There are defined as services that are provided to a beneficiary who is home-bound, which increasingly is a questionable term, that must be skilled and provided on an intermittent basis. Both skilled and intermitted have created definitional problems for us for the last 20 years, since they are statutory terms that are only partially related to expectations about professional practice or what we know about the needs of beneficiaries.

Our current definitions of skilled and intermittent, in fact, are defined by a consent decree we entered into after the district court found us in violation of the law because of a previously overrigid interpretation of those terms. This overrigid interpretation, in turn, was a response to the opening of the gates created by OBRA 1980.

We have not proposed changes because we do not know enough to prepare a substitute definition. Eventually we need to have a much better statutory definition of what we are supposed to be covering when we cover Medicare home care services or, for that matter, any Medicare post-acute services.

I must say, we do not have a better definition, of hospital services, but when the program was first enacted, we had a much higher degree of professional medical consensus about what hospitals were for, what kinds of patients ought and ought not to be in hospitals. The boundaries on long-term care have been unclear and the lack of clearity of the statutory language does not help us put those types of boundaries around the program.

Mr. MCDERMOTT. I ask the question because my father, who is almost 91, had an episode of heart failure last year, and while he was in the hospital, we went down with my mother to see if we could get some kind of home health care for him after he left the hospital. He did not meet the home health care qualifications because they were using the activities of daily living as the standard by which he was judged; whether he could climb the stairs to the second floor, the bathroom was on the second floor—we were quizzed on a whole series of issues. I wonder if there is any way to be more precise about it, given the database that you now have access to.

Mr. VLADECK. Well, I think we are getting there, Mr. McDermott. I think it is an embarrassment that, as Mr. Thomas suggested, I can share with a lot of my predecessors, on how little we know about the characteristics or outcomes of home care services for the

Medicare population. But eventually, we ought to be able to come to some degree of consensus that a patient in congestive heart failure with the following treatments and the following needs, needs the following kinds of services, this is one of the hard issues that we have not addressed yet but we will need to. Which will be very different if the beneficiary has a competent caretaker at home, a spouse who is still competent and physically mobile for example, as opposed to living alone.

I think we know enough from our experience, frankly, in the Medicaid Programs and other community-based programs to begin defining the issues around which we need to get the information to put some better shape to this benefit.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Vladeck, in your answer to Mr. Stark earlier, you mentioned that HCFA was willing to take a look at another way of approaching post-acute care, maybe looking at the more holistic approach, more of a systematic, consistent type of approach.

If you were to look at that area, how would you treat some of the data collection materials, the compatibility of that data in terms of per diem, per cost, and per visit? How would that compare? Also, what would be some of your goals in looking at that data and moving to a more holistic approach?

Mr. VLADECK. Mr. Christensen, our major goal would be to identify payments associated with particular services which were associated in turn with particular patient characteristics, and then, in the overlapping circles, in the broad range, in the middle, to try to not have the payment system in and of itself push folks in one direction or another in terms of kind of facilities. You would need separate payments for residential services or hotel services. Some patients, who need very intensive rehabilitation, ought to be outside those overlapping circles in a separate category from those who need 2 hours of physical therapy a day.

Mr. CHRISTENSEN. So, you would not advocate having, say, a neutral cost as far as going to the respective site differences? Or would you go with the same type of cost on site——

Mr. VLADECK. I would say that to the extent that the clinical services are the same, we ought to be neutral across sites.

Mr. CHRISTENSEN. As far as ensuring that the development of different prospective payment systems for SNFs or home health care type agencies, would there be any incompatibility in terms of the two different types of systems?

Mr. VLADECK. Well, I think the chairman has appropriately noted that the specific payment systems for SNF, for home health, and for rehabilitation services have been awfully long in the making. And, it is imperative to get them ready to go as quickly as possible. But we are looking very closely at areas of overlap in definitions of patient characteristics, of services, and so forth, so that we do not get too far away from a track that would permit us to move toward a unified payment system.

We have to do this as a first step because it has been so long in coming, but we want to make sure it does not eliminate the pos-

sibility of moving from there to a more integrated system across service type.

Mr. CHRISTENSEN. What type of timeframe are you looking at in this type of approach?

Mr. VLADECK. We are ready to implement a SNF perspective payment system for 1998. We think a true case-mix-based system for home care will probably take until 1999. We probably ought to watch those for a couple of years before we move into the development of a more integrated kind of system. I think we are talking about 5 years, plus/minus, to be able to go to a unit of payment that is associated with post-acute needs but not associated with a particular category of provider.

Mr. CHRISTENSEN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Bruce, in the State of Wisconsin for years they have had a Community Options Program, COPs, which has resulted in the State saving dollars on skilled nursing care, and we are talking apples and oranges because there the State savings naturally would come out of the Medicaid Program. But my question to you is, since we see rapid growth in this provided coverage, do we not see any offsets in other portions of the Medicare Program with the home health benefits?

Mr. VLADECK. No, we have not seen other offsets, and, in part, this is because of the way we pay for hospital care. We have clearly seen a very dramatic reduction in hospital length of stay for a whole variety of reasons since the Prospective Payment System was put into place. But since we are paying the same amount for a hospitalization, whether it is 6 or 10 days, if the hospital stay is shortened because a patient moves into community-based care or home care in the 7th day rather than the 11th day, that is an increase in total costs in the Medicare Program.

Part of the issue is some of the long-term care providers have suggested maybe that the only way to save money over time from the expansion of long-term care services is by appropriately offsetting reduction on the hospital side, which also would require, of course, statutory change, and we are beginning to look at some of the specifics of what that might require.

Mr. KLECZKA. Your office has reported, and I think GAO has also reported, on fraud and abuse in the home health program and the skilled nursing program. What is being done about that from your agency standpoint? And what can Congress do to help in that regard?

Mr. VLADECK. Well, home health agencies in particular have been the focus of Operation Restore Trust, which is the President's initiative to bring together HCFA, the Inspector General, the FBI, the Department of Justice, State Medicaid fraud agencies to combat fraud and abuse in our health care programs. In particular, we are doing three things with home health agencies.

First, in the five Operation Restore Trust States, we are cross-matching Medicare and Medicaid claims data for individual clients to make certain that we are not being billed twice for the same

service or not being billed for incompatible services. We are also cross-catching SNF patients claims in these states.

Second, the inspector general has undertaken an expanded program of audit of home health agencies, both of their cost reports and of the appropriateness of the services for which they are billing.

And, third, what is——

Mr. KLECZKA. If I can interrupt, that would also include overutilization?

Mr. VLADECK. That is absolutely correct, yes.

Mr. KLECZKA. OK.

Mr. VLADECK. Our third effort may have the greatest long term payoff. In three of the five Operation Restore Trust States—and we are going to be adding the other two very soon—we have, for the first time, connected the licensure and inspections work of the State survey and certification agencies with the operations of the program integrity people. We are having the Medicare home health intermediaries identify for surveyors particular agencies and patients about whose billing patterns they are concerned with. So, when the surveyors do their regular inspection of the home health agencies, they know to look at the necessity and appropriateness of services provided in those agencies to those patients. This is proving to be a very cost-effective way of looking in much more detail at what is going on in those providers.

Mr. KLECZKA. Fine. Thank you very much.

Mrs. JOHNSON [Presiding]. Thank you. I am going to try to finish quickly so that you can leave and not wait through these votes.

First of all, I am really appalled at what I hear from my home health agencies, which is that they get paid $80 for a 1-hour visit but their home health aide gets paid $8. Why can't you look at that margin?

Mr. VLADECK. Well, we have a——

Mrs. JOHNSON. I just hear that over and over. The numbers may not be exact agency to agency, but the difference between what the home health aide gets paid and what the agency gets paid is odd.

Mr. VLADECK. Mrs. Johnson, I could not agree with you more. We are on a cost-based system that permits the allocation of a whole variety of agency costs on top of the hourly wages of the aide. The limits we have are nationally determined per visit limits that do not get very well to the question of how those dollars are allocated between the agency and the actual worker.

Mrs. JOHNSON. Are you doing any analysis, and are you doing any work to deal with that?

Mr. VLADECK. Well, we think the answer is to move away from a cost-based system altogether.

Mrs. JOHNSON. Even in an episode-based reimbursement system, you really have to know costs.

Mr. VLADECK. There have been efforts in home health in California and in other parts of the long-term care service system to adjust payment mechanisms to improve the allocation of the revenue between the actual employees and the overhead functions of the provider so that more payment reaches the employee who is actually delivering the care. Apart from the policy questions about that

kind of micromanagement, such efforts have always turned out to be pretty much unenforceable.

Mrs. JOHNSON. Does HCFA have the authority to reinstate the waiver of liability for claims paid in error that expired?

Mr. VLADECK. I do not believe so. I think that was statutory. We certainly——

Mrs. JOHNSON. Could you get back to me with a clear answer on that?

Mr. VLADECK. Pardon?

Mrs. JOHNSON. Would you get back to me?

Mr. VLADECK. I would have to check. Yes, I certainly will.

[The following was subsequently received:]

Our statutory authority to make "favorable presumptions" expired on December 31, 1995, and it is unclear to us whether we could reinstate this policy administratively. Even if we could, it has been HCFA policy since 1986 to oppose further use of favorable presumptions because favorable presumptions permit automatic payment for noncovered care. Reinstatement of the favorable presumption for HHAs, SNFs, and hospices would add about $100 million in annual costs to the Hospital Insurance (HI) trust fund, as estimated by HCFA actuaries.

Mrs. JOHNSON. OK. Thank you. And then you mentioned in your testimony that you expect to implement a PPS for home care soon. How soon?

Mr. VLADECK. As I said, I expect to begin testing a system of case-mix measurement for PPS. We are testing——

Mrs. JOHNSON. The problem with that is that costs are rising so rapidly.

Mr. VLADECK. Yes.

Mrs. JOHNSON. We really do not have 3 years, and that has been your prediction.

Mr. VLADECK. Both the conference agreement proposal and the administration's proposal seek to achieve significant savings in the interim before we go to a fully prospective payment system for home health. It is not something we want to live with long term because of some of the potential negative impacts of putting such tight cost limits without appropriate case-mix adjustments. We quite agree, and I think that is one of the areas of common ground where we need to do something very quickly on the cost side. Then, as soon as the technology is available, we can move to a truly case-mix basis.

Mrs. JOHNSON. I think we may have to be more aggressive than that. What I heard you say in answer to a preceding question is that the DRG system is now preventing us from realizing the reduction in hospital costs that would help pay for the increase in home health costs?

Mr. VLADECK. Well, I would refine that a little bit by saying the combination of the DRG system and the congressionally mandated update amounts has limited our ability to take those savings.

Mr. MCCRERY [Presiding]. Mr. Vladeck, I think Mr. McDermott has one more question he wants to ask you before we can let you go.

Mr. McDermott.

Mr. MCDERMOTT. In your thinking about this whole issue, what has been your experience recently? Some say that the whole debate we have had in the Congress has moderated health care costs; at

least it seems like health care costs are coming down. Is that the experience in home health care since 1993?

Mr. VLADECK. No. The growth in Medicare home health expenditures varies from region to region and is fueled, at least in part, by the extraordinary continuing growth in the number of agencies participating in the program. And that is one of the things that I referred to in my written testimony is rewriting our basic requirements for home care agencies to raise the bar and the quality expectations about agencies in a way that we think will begin to address some of those issues.

But we do not see any significant sign of deceleration in the growth of home health expenditures. SNF has also grown very rapidly, I think in part Because of some policy decisions we made to make it easier for facilities to qualify for exceptions on the basis of their case mix. Because of our failure to get a case-mix-based prospective system in time, that has turned out to be quite expensive.

Other areas the growth has moderated more. Certainly in durable medical equipment we have seen some considerable moderation. In other parts of the program, we have seen some moderation. But home health and SNF have continued to grow very rapidly. Since we and Medicaid are essentially the only payers for most of the nursing home and home health services, and they are the fastest growing components of national health expenditures. It is one of the reasons why, after years of the pattern being different in the last couple years, Medicare costs have diverged so significantly from private sector costs.

Mr. MCDERMOTT. Thank you.

Mr. MCCRERY. Thank you, Mr. Vladeck, very much.

Mr. VLADECK. Thank you, sir.

Mr. MCCRERY. Our next panel is Mr. Newhouse and Dr. Young. If they would come forward and take seats, we will begin your testimony.

Mr. Newhouse and Dr. Young, your prepared testimonies will be entered into the record in their entirety, and if you would, summarize those for us. We will begin with Mr. Newhouse.

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. NEWHOUSE. Thank you very much. Good afternoon, Mr. Chairman. I am Joseph Newhouse, the Chairman of the Prospective Payment Assessment Commission, accompanied by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here today to discuss the development of prospective payment systems for post-acute care. I am going to refer to a number of charts that are appended to my written testimony.

As has been noted, Medicare payments for post-acute care are the fastest growing part of the Medicare Program. These increases in spending are driven primarily by increases in volume. Medicare has modified its policies over the years to contain the payment per unit of service, but its ability to control volume has been more

problematic. I am going to try to describe deficiencies in current payment and coverage policies that I think are responsible for this.

Let me first talk about SNF payments. Part of the growth in SNF spending has been due to increases in the number of beneficiaries receiving care and the total days of care provided. Between 1990 and 1995, as you see on chart 3, both the number of beneficiaries and the total days of care grew about 9 percent a year. But the largest contributor to SNF spending increases has been the growth of ancillary services provided during the stay.

Unlike the routine costs, the room and board costs, which are subject to payment limits, the payment for ancillary services is virtually unconstrained.

A third factor, in addition to the increases in beneficiaries and the role of ancillary services that has played a role in increasing SNF spending, has been new providers. New providers are exempt from the routine spending limits for up to their first 3 years of operation. Between 1990 and 1995, the number of new providers has increased by 4,000, which is a 40-percent increase.

Now, one might expect more post-acute care as hospital inpatient length of stay declined, but the ProPAC analyses of these changes since the beginning of PPS do not indicate any strong association between changes in the length of stay and increases in SNF service use. So, we are skeptical that the increased use in the nineties is much related to changed patterns of inpatient use.

Let me now turn to home health. That has also increased by an average of 33 percent a year since 1990. That has not been due primarily to per visit payment increases. They have been growing at just 3 percent a year, as shown in chart 5. The principal reason for the escalation of home health spending has been an unchecked growth in the number of visits. Between 1990 and 1995, the number of visits more than tripled. That is due to an increase in the number of beneficiaries using home health services, which doubled from about 5 percent to 10 percent of the Medicare population, and it has also been an increase in the number of visits per user, which has also doubled. In 1990, the average number of home health visits per user was 35, and by 1995, it was 70, as shown in chart 6.

The nature of the home health benefit is also changing. In 1993, nearly half of the visits were for AIDS services, which include the personal care services such as bathing, dressing, and grooming, while in 1988, 5 years earlier, those services comprised only a quarter of the visits.

Now, unlike the SNF benefit, Medicare beneficiaries do not need a prior hospital stay to receive home health services, and, in fact, only 60 percent of the home health episodes in 1994 were preceded by a stay. Also, unlike most other Medicare benefits, home health has no cost sharing.

There has also been a large number of new entrants into home health between 1991 and 1995. The number of agencies grew by 50 percent, primarily proprietary agencies, provide more aide visits and more total visits than other agency types.

There has been wide agreement that we need a system to control this spending growth. Both the Subcommittee and the administration have proposed prospective payment systems to do so. The

Commission strongly supports prospective payment for these services and other providers as well. But this is not an easy task.

As has been alluded to, there are ill-defined coverage policies and very inconsistent policies across sites.

Two of the most important issues in designing a prospective payment system relate to defining the unit of payment and developing a case-mix measure. The most extreme form of aggregation, of course, is an annual capitation payment. Less extreme would be bundling with the hospital admission or an episode payment for just the post-hospital stay.

Those have all a variety of implementation issues, and we believe that a first step would be to move toward an episode of care payment for a particular service such as a SNF admission.

The development of the case-mix measure is critical. The reliable case-mix measures to adjust SNF or home health payments do not now exist, and without that, there will be an incentive to avoid complex patients.

Let me with that, Mr. Chairman, stop and try to answer your questions.

[The prepared statement and attachments follow:]

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good afternoon, Mr. Chairman. I am Joseph Newhouse, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here today to discuss the development of prospective payment systems for post-acute care, including skilled nursing and home health services. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Payments to post-acute care providers, including rehabilitation facilities, long-term care hospitals, skilled nursing facilities (SNFs) and home health agencies, are the fastest growing portion of the Medicare program. SNFs and home health agencies account for the vast majority of these payments. Between 1990 and 1995, Part A payments to these two providers more than quadrupled, from $6 billion to $26 billion (see Chart 1). By contrast, the rest of Medicare Part A payments grew only 50 percent over this period. As a result, the share of overall Part A spending represented by SNFs and home health agencies has grown from 10 percent to 22 percent (see Chart 2). This payment growth is becoming an ever larger contributor to the approaching insolvency of the Part A Trust Fund.

The increase in skilled nursing facility and home health expenditures is driven primarily by increases in the volume of services provided. While Medicare has modified its polices over the years to slow the rise in the payment per unit of service, its ability to control the number of services furnished remains elusive. As I will describe shortly, this is due to deficiencies in current payment and coverage policies.

This afternoon I would like to discuss several factors responsible for the growth in spending for skilled nursing facilities and home health agencies. These factors clearly illustrate the need to develop and implement prospective payment systems for post-acute care. Developing such systems is not an easy task, however, and I will discuss some of the problems that must be overcome to develop policies that will slow spending growth, while maintaining access to needed care for Medicare beneficiaries.

SNF Payments

Over the past five years, Medicare SNF payments have grown, on average, 33 percent a year. Medicare pays for up to 100 days of SNF care per spell of illness for beneficiaries who recently have completed a minimum three-day hospital stay and are in need of skilled nursing or rehabilitative services on a daily basis. A beneficiary copayment that is equal to one-eighth of the hospital inpatient deductible begins on the 21st day. In 1996, this copayment amount is $92.

Medicare pays facilities separate amounts for routine services, ancillary services, and capital. Payments for routine services, which include room, board, and skilled nursing services, are based on facility-specific costs subject to national limits based on average per diem costs. Capital costs and those for ancillary services, such as physical therapy, occupational therapy, speech therapy, laboratory tests, and radiology procedures, are reimbursed on a facility-specific cost basis without limits.

Part of the growth in SNF expenditures has been due to increases in the number of Medicare beneficiaries receiving care and the total days of care provided. Between 1990 and 1995, the number of beneficiaries and the total days of care grew at the same rate, about 9 percent a year (see Chart 3). The average Medicare-covered SNF stay was about 27 days in 1994, which appears to have remained relatively constant over this period. This stability may be related to Medicare's SNF copayment requirement, which begins after 20 days of care.

The largest contributor to the SNF expenditure spiral has been the growth in the volume of ancillary services provided during a stay. Unlike routine costs, which are subject to payment limits, payments for ancillary services are virtually unconstrained. For the most part, SNFs are paid their costs for these services subject only to Medicare's "reasonableness" criterion and certain salary limitations for therapists. High ancillary costs also can boost payments indirectly because above-average ancillary service use can be a justification for an exception from Medicare's routine cost limits.

Medicare beneficiaries are receiving more ancillary services during their SNF stays than ever before. It is difficult to precisely quantify the volume of ancillary services that are being provided because facilities are required to report only their charges to Medicare. But between 1990 and 1994, charges for ancillary services grew from 15 to 30 percent of total Part A skilled nursing facility charges.

New providers also have contributed to growing SNF expenditures because many of these facilities are exempt from the routine per diem limits for up to their first three years of operation. This policy was implemented to recognize the start-up costs of new providers. Between 1990 and 1995, there were 4,000 new SNF providers, including both hospital-based and free-standing facilities, raising the total number of SNFs to over 14,000.

Mr. Chairman, routine cost growth has been constrained somewhat through cost limits; for example, these limits were frozen in 1994 and 1995. As a result of these constraints, SNF per diem cost limits rose only 13 percent between 1990 and 1995, from $91 to $103. But, average SNF payments per day more than doubled over this period, from $100 to $265. This was due to increased ancillary service use and the higher routine payments to new providers, as well as capital reimbursement and exception payments above the routine cost limits. As a result, there is a growing divergence between Medicare's routine cost limits and what the program actually pays for each SNF day (see Chart 4).

While one might expect to provide more post-acute care as hospital inpatient lengths of stay decline, ProPAC analyses of these changes since the beginning of PPS do not indicate a strong association between changes in length of stay and increases in SNF service use. Thus, we do not believe the increased use in the 1990s is much related to changed patterns in inpatient use.

Home Health Payments

Medicare home health expenditures also have increased by an average of 33 percent each year since 1990. To qualify for the home health benefit, beneficiaries must be homebound and require skilled nursing services, or physical or speech therapy on a part-time or intermittent basis. If these conditions are met, beneficiaries may also receive occupational therapy, home health aide, or medical social services. Agencies are paid their costs for home health services, subject to limits based on national average per visit costs.

Home health expenditure growth has not been due primarily to per visit payment increases--these payments have been growing at less than 3 percent per year, on average (see Chart 5). The principal reason for the escalation has been an unchecked growth in the number of home health visits.

Between 1990 and 1995, the number of home health visits more than tripled, from 69 million visits to over 252 million visits. This is due to increases in both the number of beneficiaries using home health services and the number of visits each of these beneficiaries received. In 1995, about one-tenth of all Medicare beneficiaries received home health services, nearly double the number of recipients in 1990.

Even more striking is the fact that the number of visits per user also doubled. In 1990, home health users averaged 35 visits per year. By 1995, this had risen to 70 visits (see Chart 6). A growing percentage of home health recipients are receiving more services over longer periods of time. In 1993, 16 percent of home health recipients received 100 or more visits, accounting for 62 percent of all visits in that year. ProPAC analyses also indicate that home health episodes of care are lasting much longer than previously. Between 1990 and 1993, home health episodes of care lasting longer than three months increased from 19 percent to 25 percent of all episodes.

The nature of the home health benefit also is changing. In 1993, nearly half of all home visits were for aide services, which include personal care services--such as bathing, dressing, and grooming--simple wound dressing changes, and assistance with medications. In 1988, these services comprised only a quarter of all home health visits. ProPAC's work shows that very long home health episodes (166 days or more)

are dominated by aide visits, while shorter episodes and those following a hospitalization have proportionately higher skilled nursing and therapy visits.

The recent increases in home health use result from a relaxation of Medicare coverage requirements in 1989, largely in response to a court decision. These revisions enabled more beneficiaries to qualify for the benefit and expanded the number of services each could receive. Unlike other Medicare facility services, there are no limits on the number of days of care that may be furnished, as long as a physician periodically certifies a need for skilled nursing services or physical or speech therapy.

In addition, unlike the SNF benefit, Medicare beneficiaries do not need to have a prior hospitalization in order to receive home health services. In fact, only 60 percent of home health episodes in 1994 were preceded by a hospital stay. Finally, unlike most other Medicare benefits, home health care has no beneficiary cost-sharing requirements.

Access to home health services also is growing as the number of home health agencies increases. These agencies may be hospital-based or freestanding facilities. Between 1991 and 1995, the number of agencies grew by 50 percent, driven by increases in proprietary agencies. Proprietary agencies generally provide more home health aide visits and more total visits than other agency types.

Controlling Post-Acute Care Expenditures

As you can see, Mr. Chairman, there is a pressing need to control post-acute care spending growth. Over the past year there have been proposals put forth by this Subcommittee and the Administration to institute prospective payment systems for both skilled nursing facilities and home health agencies to control Medicare expenditures. The Commission strongly supports prospective payment for these, and all, providers. Payment methods that move away from cost-based reimbursement can slow expenditure growth while encouraging providers to deliver care in the most efficient manner.

As you know, however, controlling expenditures is not an easy task. This is particularly true in the post-acute care arena because, as I have described, much of the growth in post-acute expenditures is related to the number of beneficiaries receiving these benefits as well as the number of services provided. These factors are related to ill-defined coverage policies, especially for home health benefits, that resulted largely from court decisions in the late 1980s. While many of the services provided are presumably reasonable, necessary, and medically appropriate, it is nearly impossible to identify those which are or which are not. In addition certain covered services, such as home health aide visits, provide important supportive services, but generally extend beyond Medicare's traditional coverage of acute care medical benefits. While many, if not most, of these services may be of value to Medicare beneficiaries, it is not clear their value is commensurate with their additional cost to the Medicare program.

Further, coverage and payment policies must be considered in the context of all the settings where post-acute care may be delivered. There is a large overlap in the types of services that SNFs and home health agencies deliver. Other facilities, such as rehabilitation facilities, long-term care hospitals, and ambulatory facilities, also provide many of these services. A recent ProPAC analysis examined the use of post-acute providers by individuals hospitalized with the same diagnosis-related group (DRG). For those DRGs in which a significant share of the patients used post-acute care, utilization was spread across provider types. One-quarter of beneficiaries hospitalized with a hip fracture (DRG 209), for example, used only home health care, while almost 20 percent went to a SNF (see Chart 7). An additional 20 percent of beneficiaries used two or more post-acute care providers.

The choice of a post-acute provider is affected by several factors, including patient needs and provider supply. It is very likely that Medicare payment polices also affect these choices. To the extent that payments are constrained in one setting, care may be shifted to other settings thereby increasing overall Medicare spending. Actions by providers faced with payment limits also could result in beneficiaries

receiving additional services. For example, a prospective, episode-based payment system for post-acute care only could increase the incentives for a patient to be discharged from a hospital to a skilled nursing facility for period of time, then subsequently be referred for home health services.

The Commission believes that payment methods and incentives should be consistent and coordinated across all delivery sites. For several years, HCFA has been sponsoring research and demonstration projects to develop prospective payment systems for post-acute services. Despite the similarity in services furnished by these providers, these projects have not been coordinated. In addition, much of their focus has been on per diem or per unit payment techniques. These types of prospective payment systems will do little to control the major problem driving expenditure increases: the growth in service volume.

Prospective Payment Systems

Two of the most critical issues in designing a prospective payment system relate to defining the unit of payment and developing a case-mix measure.

Establishing an appropriate unit of payment is critical to controlling the volume of services provided. Ideally, this unit should include all of the services associated with a full episode of care. In the hospital inpatient setting, for example, hospitals receive a payment for each admission to cover all of the services provided during that admission.

An annual capitation amount that covers all medical care for a person, such as used to pay managed care plans, is the most comprehensive unit of payment. Evidence indicates that such an all-inclusive payment is associated with different patterns of post-acute care use. A ProPAC analysis of state per capita Medicare spending showed that in states with high managed care penetration, skilled nursing facility services were used slightly more than the national average and home health services were used much less. Less extreme than a per capita amount for all services would be an episode-based payment that would cover all post-acute services or all services associated with a hospital admission. Given the difficulties in implementing this type of approach quickly, however, separate episode payment mechanisms for each type of post-acute facility is a more feasible alternative at the present time.

Currently, SNF and home health agency payments are subject to per day or per visit limits. Simply moving to a prospective per diem or per unit payment system, however, would do little to control the increase in the volume of services. In fact, it could encourage providers to increase the number of SNF days of care or home health visits unless related policies were implemented to control volume.

As a first step, the Commission believes that prospective payment should cover all of the services furnished over an appropriate episode of care, such as a SNF admission. For example, a prospective payment for SNFs should include routine and ancillary services, as well as capital. In general, the more services that are covered under a prospective rate, the stronger the incentives for providers to appropriately manage the mix of services a patient receives. Defining an appropriate episode for home health is more difficult because it is harder to establish when treatment begins and ends. As I have described, for some beneficiaries, home health care involves primarily supportive services furnished over many months or even years.

Eventually, Medicare could consider bundling the payment for post-acute care with the payment for inpatient hospital care. While this approach raises the problem of which entity should receive the payment, it could provide Medicare with greater control over total expenditures for an episode of care and might ensure that beneficiaries receive a continuum of care in the most appropriate settings. This solution would be most effective in controlling SNF expenditures because beneficiaries must have been hospitalized prior to receiving SNF services. By contrast, this solution alone would not affect spending for the substantial number of home health users who do not have a prior hospitalization.

While possibly the best course of action, prospective payment for an episode of care, with or without a link to hospital payment, is not without its shortcomings. While

fee-for-service payment methods provide incentives to increase the number of services furnished, episode-based systems contain incentives for providers to reduce care. Without an appropriate measure of resource costs for each episode that reflects an individuals' needs, such a system also could also encourage providers to seek out the least complex patients. A case-mix measure is frequently used to match the relationship between resource costs and patient needs.

A case-mix measure is necessary to ensure that the per episode payment reflects the resources necessary to provide care appropriately while, at the same time, encouraging efficiency. Payment rates that do not accurately reflect appropriate resource use have the potential to either increase expenditures if they are too high or reduce access to care if they are too low. In the hospital inpatient setting, hospitals receive a payment for each admission that varies depending upon the diagnosis-related group (DRG) to which the patient is assigned. The DRG payment rates are based on individual patient characteristics and estimated resource use.

Currently, a reliable case-mix measure that could be used to adjust SNF or home health payments does not exist, although HCFA has been actively conducting research in this area. In the hospital setting, a patient's diagnosis is used to predict resource use. It is not as useful in the post-acute care area, however, because patient needs vary widely, even for those who share the same diagnosis. A case-mix system that differentiates patients based on their functional needs, cognitive limitations, and social situation may better predict resource need.

Certain research initiatives categorize patients according to the intensity of services they receive in a post-acute setting, such that patients who used more services would be presumed to have needed more resources. A payment system that relies on this type of case-mix adjustment, however, contains incentives for providers to increase the volume of services they provide to receive higher payments regardless of the needs of the patient. Nonetheless, as I will discuss in a moment, such a payment system may serve us well in the interim as we develop appropriate measures. Such measures correlate resource use with functional needs, such as the ability to perform certain activities associated with daily living. In this way, the complexity of the patient, and coordinated payment rate, would be based on objective criteria that are not associated with service use.

The need to develop a robust case-mix measure for post-acute care services as soon as possible cannot be overemphasized, Mr. Chairman. In the meantime, however, other mechanisms must be implemented to help constrain service use. For SNFs, these payment constraints should focus particularly on ancillary service use, which is a significant contributor to current growth. One approach that I find attractive is to transition from today's policies to a full episode-based system. For example, during the transition, payments could be based on a mix of per diem payments or per visit payments and a portion of a full episode payment. Over time the proportion of the payment that is episode-based could be progressively increased. A transition would allow time to collect data and to improve the case mix measure, as well as to modify other policies if the need arises.

Other Policy Considerations

While PPS may help constrain post-acute expenditures, alone it may not overcome increased expenditure growth associated with increases in volume, particularly the rise in the number of beneficiaries using these benefits. The lack of clear and enforceable coverage requirements opens the door to continued increases in SNF admissions, particularly where PPS payment policy encourages hospitals to discharge patients as early as possible.

The Medicare program has even less control over the appropriate use of the home health benefit. The lack of a prior hospitalization requirement, the rise in the number of home health agencies, and the ease of receiving services at home could substantially increase the number of beneficiaries receiving this benefit from the current level of 10 percent.

While the Commission supports episode-based payment systems, I personally continue to be concerned, especially with regard to home health, that an episode

system provides very strong incentives for agencies to admit new individuals that require only a small amount of care. Without proper controls or adjustments, agencies could reap windfall payments. Although I don't have a good solution for this problem at the moment, I believe it must be addressed, and ProPAC would be happy to continue to work with you and your staff on it.

The Commission also believes that implementing a cost sharing policy for home health services, just as there is for virtually all other Medicare benefits, would help to constrain service use that is marginal medical value. The Commission has recommended that any copayment policy, however, should be subject to annual limits such that access would not be restricted inappropriately.

Mr. Chairman, I am aware that the issue of Medicare's presumptive waiver of liability policy has been brought to the attention of the Committee. In general, Medicare does not pay providers for claims they submit for services that are not covered by the Medicare program. Medicare, however, has paid for some of these denied claims if they were denied because they were determined to be not medically reasonable and necessary and the provider could show that it did not know or could not have known that the services were not covered.

For a number of years, both home health agencies and SNFs automatically received payments for denied claims if the number of these claims were below a certain threshold, 5 percent for SNFs and 2.5 percent for home health agencies. Agencies that have claims below this threshold were presumed to not have known that the claims were not reimbursable. This presumptive waiver of liability expired in 1995, but some would like this policy reinstated.

The continued need for this policy is questionable. It was introduced during a period when implementation of coverage rules was stringent but inconsistent, and facilities faced uncertainty. The rules that were in place at that time are no longer in force, and as I noted there are now few limits on coverage. This policy also relieved providers of the responsibility to ensure that all the services they provide are appropriate and reimbursable under Medicare. Given the dramatic increases in the use of post-acute services, the need to reinstate the presumptive waive of liability should be considered carefully.

Conclusion

Mr. Chairman, payments for post-acute care services, particularly for skilled nursing facilities and home health providers, are growing at an unsustainable rate. Completing necessary research and implementing well-designed, case-mix adjusted, prospective payment systems for all post-acute providers must be given a high priority. ProPAC is continuing work in this area, and we look forwarding to working with the Subcommittee as you seek to improve and preserve the Medicare program.

This completes my formal testimony, Mr. Chairman. I would be pleased to answer any questions from you or other members of the Subcommittee.

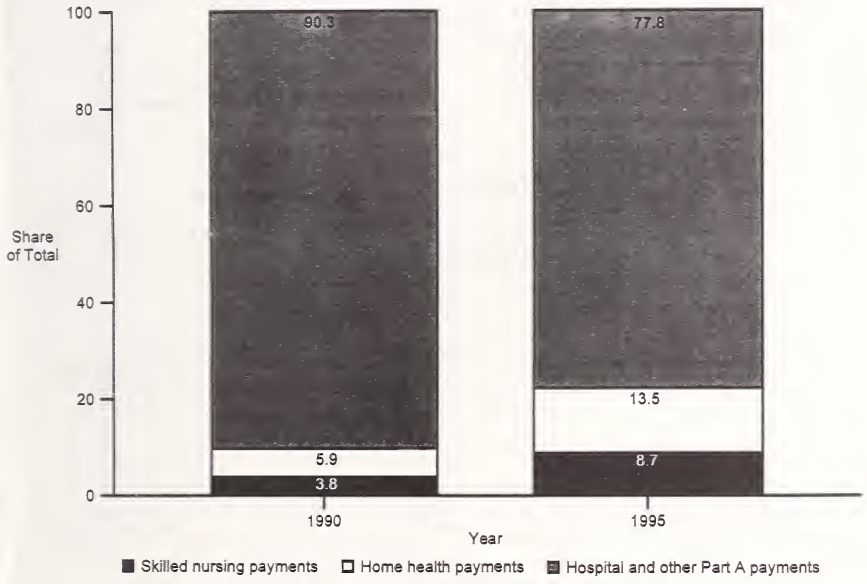
Chart 1. Medicare Skilled Nursing Facility and Home Health Agency Payments, 1990-1995 (In Billions)

Year	Skilled Nursing Facility	Home Health Agency
1990	$ 2.5	$ 3.9
1991	2.9	5.7
1992	4.5	8.0
1993	6.4	10.4
1994	8.3	13.6
1995*	10.3	16.2
Average Annual Increase	33%	33%

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 2. Medicare Skilled Nursing Facility and Home Health Agency Payments as a Share of Total Part A Payments



Note: Payments represent program liabilities and do not include beneficiary copayments.

Chart 3. Medicare Skilled Nursing Facility Payments and Use, 1990-1995

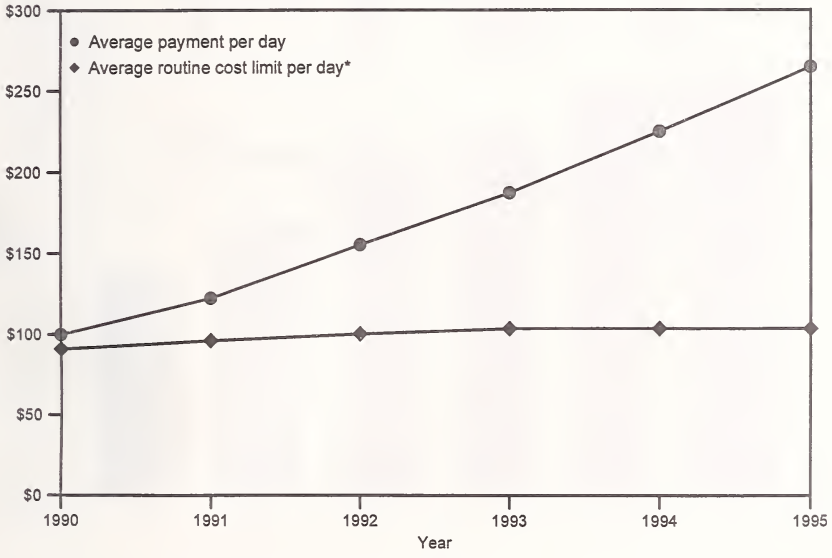
Year	People Served	Days (In Millions)	Payments Per Day
1990	638,000	25.1	$100
1991	671,000	23.7	122
1992	785,000	29.0	155
1993	908,000	34.3	187
1994	945,000	36.9	225
1995*	990,000	38.8	265
Average Annual Increase	9%	9%	22%

Note: Payments are incurred Part A expenditures rather than outlays and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 4. Medicare Average Payment Per Day and Routine Cost Limits, 1990-1995



* Estimates based on rates effective on the first day of each fiscal year.

Chart 5. Medicare Home Health Agency Payments and Use, 1990-1995

Year	People Served	Visits (In Millions)	Payments Per Visit
1990	1,940,000	69.5	$56
1991	2,223,000	100.2	56
1992	2,523,000	135.6	58
1993	2,868,000	169.4	61
1994	3,325,000	221.9	60
1995*	3,615,000	252.3	63
Average Annual Increase	13%	29%	3%

Note: Payments are incurred expenditures rather than outlays and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 6. Medicare Home Health Visits Per Person Served, 1990-1995

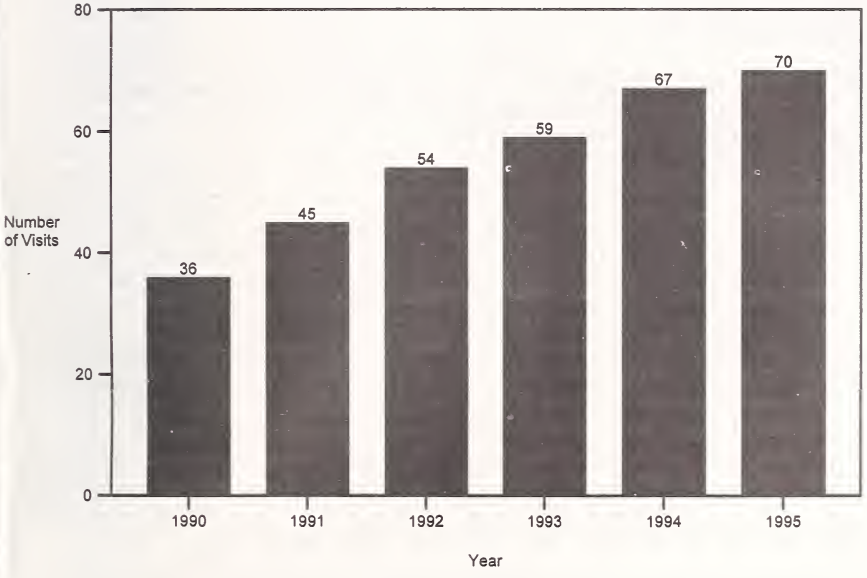


Chart 7. Post-Acute Care Provider Use Within 30 Days of PPS Hospital Discharge, Selected DRGs, 1994

Provider	Beneficiaries (In Percent)		
	DRG 209[a]	DRG 14[b]	DRG 471[c]
Skilled nursing facility only	18.8%	19.8%	12.3%
Home health agency only	25.5	12.3	23.1
Rehabilitation facility only	8.6	9.5	14.7
Long-term care hospital only	0.3	0.5	0.4
More than one	20.4	9.2	29.9
None	26.4	48.7	19.7

Note: DRGs were assigned during PPS hospital stay. PPS = prospective payment system. DRG = diagnosis-related group.

[a] Major joint and limb reattachment procedure of lower extremity.

[b] Specific cerebrovascular disorders except transient ischemic attack

[c] Bilateral or multiple major joint procedures of lower extremity.

Mr. MCCRERY. Thank you, Mr. Newhouse.

Dr. Young, did you want to add anything before we go on to questions?

Dr. YOUNG. No.

Mr. MCCRERY. Well, as you pointed out in your testimony, there are probably more questions than answers, at least right now. However, we all acknowledge that we have very little time to come forward with some solution to try to constrain the growth of cost.

I wonder if you might give us some idea of the difficulty, though, that we face by going through for us a common example of someone seeking post-acute services and the various alternatives that they have, say somebody that gets a hip replacement and then he wants to choose some form of post-acute services. Just go through for us the different options that that person has and describe the various reimbursement options.

Mr. NEWHOUSE. I am glad you picked that example, Mr. Chairman, because if you look at chart 7, we have the data on exactly how Medicare beneficiaries with hip fracture sort themselves out across alternative settings. You will see that just under a fifth use a skilled nursing facility; about a quarter use a home health agency; a little under 10 percent use a rehabilitation facility. Those percentages are people that use only those facilities. A fifth use more than one, and a quarter use none of the above. So, this really makes the point very nicely that people who need these services may get them in a variety of settings and the need to try to keep payment policy neutral toward what setting is used.

As I said in my written testimony, if we do something for just one service, we run the danger that we will artificially push people toward another site of care for these services.

Mr. MCCRERY. Given that wide range of choices, as we go through this exercise of trying to develop a prospective payment system, what should our goals be? And what do we want to accomplish?

Mr. NEWHOUSE. Well, in the larger sense, of course, we want to deliver an appropriate set of services in an efficient way. One of the problems in this area is that there is little agreement on what constitutes appropriate services, as Bruce Vladeck said.

There is also disagreement on who is eligible for those services or some ambiguity about who is eligible.

An episode payment gives an incentive to be efficient in delivery of care. Unfortunately, it also gives some incentives to offer care to beneficiaries that might not have been receiving it before. For example, if we take the home health visit rate of 70 visits per person and we say that is what we will base an average episode payment on, and I now have a person that could use a relatively small number of visits following some relatively short stay, maybe now that person is not getting any, but now I have a strong incentive to offer that person a few visits and collect a fairly large episode fee.

It is for that reason that I suggested in the testimony that we consider a mixture, at least during the transition, of a partly episode-based payment and a partly visit-based payment, or at least a payment that moved partly with the number of units of service. This is now me speaking personally rather than for the Commission.

Mr. McCrery. OK. Thank you.

The gentleman from California.

Mr. Stark. I am looking at a couple of instances, Mr. Newhouse. We hear today that hospital-based SNFs cost more than freestanding SNFs. There is, however, a State of Florida study that shows that Florida hospitals send sicker and older patients, and presumably less profitable, out to the freestanding SNFs and keep the healthier patients for themselves.

Do you think problems like this are just occasional and anecdotal at best? Or do you think that as we have different payment systems for all these different entities, that a certain amount of—I hate to use the word "gaming" because people like to maximize their returns, but there is a certain amount of learning that the people who manage care can figure out and use to maximize their returns. Is this a problem that we ought to look at, or is it just an occasional result of local custom?

Mr. Newhouse. I do not have an answer for that question. I do believe, Don may be able to correct me, that the length of stay-in hospital-based SNFs, if we go back and we look at the preceding stay, was shorter than in the freestanding SNFs. Is that correct?

Dr. Young. That is right.

Mr. Newhouse. The problem is trying to disentangle whether the hospital-based SNFs have shorter preceeding hospital stays because they are substituting days in the hospital for days in the SNF or whether there really is a different case mix that is coming out. At least as I read the existing data, we do not know how to disentangle that. It goes back to the issue of trying to develop some kind of case mix adjusters for any kind of episode-based system.

Mr. Stark. Well, I think that is where—Dr. Young, is not—the closer we get to a universal bundled payment, in my opinion, the sooner we will get to a fairer payment structure. Is that possible, in your opinion?

Either one, both. Is it possible to take an appendectomy or a hip replacement and say, we'll bundle the whole thing—surgery, anesthesiology, hospital, SNF, rehabilitation, the whole ball of wax—and then let the providers duke it out as to who's going to be the manager, the physician, the hospital, the insurance company? I mean——

Mr. Newhouse. In one sense we have the extreme of bundling now in the at-risk side of Medicare and that bundles it all. As for bundling hospital admission in traditional Medicare, a very important question is, what that would do, within DRG variation in payments or dispersion. As you know, one of the goals of the DRG system is to try to minimize variation and have a fixed payment for a relatively homogeneous person.

I have not seen the recent data showing how that would be affected. I hope that we can do that as a part of our analysis this year.

Now, one safety valve on the existing system would also have to be modified which is the outlier system. At least I think it would have to be rethought a bit if we were going to bundle in post-acute.

Finally, on the home health side, 40 percent of the episodes come without any qualifying hospital stay. So, we can not bundle that part of it.

Mr. STARK. But do they come with the recommendation of a physician?

Mr. NEWHOUSE. Yes. That's required.

Mr. STARK. That must be a result of some diagnosis, some CPTD coding. The physician is not doing that for free. They are coding an office visit, a phone visit, or a nursing visit, some visit that leads to the recommendation of the home health care, right?

Mr. NEWHOUSE. Yes.

Mr. STARK. And, if you put the physician at some risk financially in that decision, they might pay a little more attention to how many home visits are made. Does that seem logical?

Mr. NEWHOUSE. Yes, or put somebody at risk, yes.

Mr. STARK. Besides the taxpayer or the patient.

Thank you.

Mr. MCCRERY. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Newhouse, you made a comment that I wanted to explore. You said that no data shows length of stays at hospitals being reduced, even though the increased use of SNFs has gone up significantly, as well as the cost.

It is my general understanding that the increased use of SNFs and home health care had reduced the stays at hospitals and I wanted to have you elaborate on that.

Mr. NEWHOUSE. The issue here is, you are certainly right that length of stay in hospitals has trended down over time and, as I have said, use of post-acute care has trended up.

What I meant to say was if you looked at the year-to-year changes over the last 12 years or so, there's not much association. In other words, in the years when length of stay falls more, it's not that post-acute increases more.

Mr. CHRISTENSEN. OK, well, just so I am clear where you stand. Because you said earlier that there was no data that showed the length of stay had gone now, and now you just said that it has trended down.

Mr. NEWHOUSE. No. I am sorry, if I said that, I misspoke. The length of stay has certainly gone down, there's no question about that. The only issue is when you try to correlate the timing and the decreases in length of stay which vary from year to year.

Mr. CHRISTENSEN. That's a major difference in statement. I appreciate your clarifying that for the record.

Thank you.

Mr. MCCRERY. The gentlelady from Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman.

In estimating the effect of PPS proposals for home care, CBO assigned a two-thirds discount against potential savings because of the potential for providers to give the intended savings. In other words, they discounted by two-thirds on the theory that the industry would be able to give away two-thirds of the savings advantage.

What's your opinion of such a budget estimating policy? This is just their policy. They do not tell us what facts it's based on but CBO just uses that two-thirds knockdown discount against potential savings. In my experience and in talking with my home health care providers, there's simply no justification for that. What is your opinion of that?

Mr. NEWHOUSE. Well, I think any estimate would be very uncertain but I am not sure what CBO had in mind. But if I were interpreting it, I would guess they were worried about the same thing that I was pointing to which is the possibility that you would introduce a number of new episodes that you're now not seeing with relatively small use.

Some people worried, at the time we introduced the hospital prospective payment system, that admissions would increase a lot from people that were only marginally necessary to be in the hospital. That did not really happen. And it might not happen here either. Probably the controls over the admission to the hospital were better than they would be over who would get home health services.

Mrs. JOHNSON. Have you done no study at all? It seems to me that when we redefined acute care and purposely shortened the stay in hospitals that you would have had in place some ability to oversee whether the home health care services being provided were appropriate.

Mr. NEWHOUSE. Well, part of the problem here is the definition of what is regarded as appropriate. There is much less medical consensus about that then there was, in the hospital stay. But you know, again, 10 percent of the beneficiaries are now getting home health care services or another way of saying that, obviously, is 90 percent are not and I think the issue in the CBO discounting, as I understand it, it is how many, if any, of those 90 percent would start to receive home health care services.

Mrs. JOHNSON. So, you do not have any data on appropriateness?

Mr. NEWHOUSE. No. And, it would be very hard to get any data because we have not paid on this basis before. I just do not know where data would come from. That's why there's a lot of uncertainty in the estimates. CBO presumably has some basis for their estimates, I do not know what it is.

Mrs. JOHNSON. Well, if you were discounting for a volume increase, can you give me some rough idea of what you might discount?

Mr. NEWHOUSE. To be frank with you, I have not thought about it very much and when I have, I have just decided it's too hard. I do not have any real data to do it with.

Mrs. JOHNSON. Well, it is being done and if you give it some thought and give me an idea of what you would think about and what you think the percentage might be. We are really stuck because we have this arbitrary situation and it means that the proposals that come from the industry are simply, in a sense, not reviewed carefully. That is not reasonable because we have agencies that have done some remarkable things to control volume and cost and, have some hard evidence. It means that that hard evidence is not considered.

I do want to ask you one other larger question. What are your thoughts on the feasibility and desirability of taking an integrated or a site-neutral approach, a more comprehensive approach to designing Medicare payment policies for post-acute care?

What I mean is, we are finding that if you merge Medicare and Medicaid long-term care payments and presumably if we begin to see home care payments differently, what we really ought to be de-

signing is a far more flexible post-acute care capability that has built into it both quality assurance and appropriateness of care indicators.

It is going to be increasingly hard for the government to decide which is cheaper, home care, long-term care, or going into a hospital for a few days. We have a very hard time allowing the most appropriate setting to be deciding what is reimbursed. And, have you given any thought to a far more integrated system?

Mr. NEWHOUSE. I think that's the direction we ought to be headed in, but it ultimately raises the issue of integrating with the Medicaid benefit, which, obviously raises a whole host of issues.

Mrs. JOHNSON. But you ought to be looking at those, too. Just because you work for us, they're all integral and they serve the same population. So, we really need help on a more integrated approach.

Thank you.

Chairman THOMAS [Presiding]. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I would like to revisit this issue, Mr. Newhouse. I was looking over your written statement and then I also saw in here similar statements to what you said earlier. I also want to ask, though, should we consider rebasing the DRG payment, in light of reduced lengths of stay at hospitals? Would that show an effect with the SNFs in terms of looking at this data?

Mr. NEWHOUSE. I am not sure it would, that simply rebasing would do very much to the SNF payment.

Mr. CHRISTENSEN. But in light of the increased use of SNFs should we look at, and the reduced——

Mr. NEWHOUSE. I understand what you're asking. I think the issue is more or less rebasing than it is just the amount of the update factor every year. That is as length of stay falls—now it becomes rebasing if it falls differentially by DRG—but as it falls more, kind of across DRGs, are we updating the payment rates in an appropriate way to take account of that fall.

We have made recommendations, over the years, for update factors that are based on such things as the productivity increase and the amount of case-mix index that is thought to be coding changes and so on and so forth.

By and large, the Congress has enacted update factors that, while not always identical with our recommendations, have been very close to them. And, so, my answer is that I think the updates have been about on target and that we have probably have taken down or raised them at a rate that was appropriate. And, therefore, in effect, this substitution has been taken into account.

Now, it's possible that that has not been done quite right, DRG by DRG. But we do adjust periodically the DRGs, so, in the relative rates, that should be picked up over time as well.

Mr. CHRISTENSEN. What kind of new data would you need to reexamine this issue?

Mr. NEWHOUSE. Well, there are some things that are very hard to adjust because they are very uncertain, such as, the amount of technological advance. The only factor I can point to that we could have better data on, on the hospital side, would be the amount of

coding change. Where we should redo some of the studies that were done about 10 years ago.

Mr. CHRISTENSEN. OK. I would like to get Dr. Young's answer on this question.

In your testimony it states that the ProPAC analysis of these changes since the beginning of PPS do not indicate a strong association between the changes in length of stay and increases in SNF service use. Thus, we do not believe that the increased use in the nineties is much related to change patterns in in-patient use.

Would you continue to stand by that statement or do you believe that the SNF's increased in use has reduced some of the hospital stays?

Dr. YOUNG. The first thing we did was to ask the question, is there a relationship at any period of time? So, we looked at length of stay changes from the beginning of PPS, 1984 through the current time.

The second thing we did was to look at the growth in SNF spending and home health spending. Since 1984, the beginning of PPS length of stay started declining rapidly at that time, until 1988 or 1989 there was no substantial change in either SNF or home health spending with dramatic declines in length of stay. So, simply looking at it temporally, over time, there was no relationship.

The growth in home health and SNF started in 1989/1990 in association with the class-action lawsuits that Mr. Vladeck talked about and changes in HCFA's coverage policies. Thereafter, spending grew very rapidly while length of stay continued to decline.

So, looking at it timewise, there was no association. The second thing that we have done over time is provide you with recommendations for annual update factors. The recommendations you have enacted have been close to our recommendations, overall slightly lower then our recommendations. In those recommendations, and implicit in your annual update factor has been a productivity adjustment. The productivity adjustment accounts for changes in how hospitals operate including changes in length of stay.

In our early years, in fact, our update included what we call the site-of-care substitution to account for these kinds of factors.

The bottom line is, therefore, I personally believe that, while you can argue around the margin, what you're paying hospitals is what you believe is an appropriate amount that incorporates the declines in length of stay that we have all observed. And that, the spending growth that's going on for SNF and home health is, indeed, related to those changes in length of stay but that the extra money, if you would, has already been taken out of the hospital through the annual updating process and you would gain nothing further by rebasing the rates.

Mr. CHRISTENSEN. Thank you, Dr. Young.

I am anxious to hear the following witnesses and their take on that same area. So, thank you Mr. Chairman

Mr. MCCRERY. They may have a different view.

Chairman THOMAS. Thank you.

I am not going to go through a series of questions because the other panel members, I understand, have done a good job in inquiring of you and getting the kind of information that we are looking

for. I do not mean to pursue something that's going to get a lot of people worried but we've been having these lunches with CRS and going into background information for staff and members because, frankly, some of this is quite complicated and has a specific history and if you do not understand that, it's hard to understand where we are now.

I have been blessed with that ignorance to a certain extent, so, I do not have to assume the obvious. I can actually ask questions. We were looking at home health care and SNF financing and the history of it several weeks ago with a number of experts.

One of the things I think that is somewhat self-evident but that there is evidence to show it clearly is that, to a very great extent and almost in its entirety, these two industries have been created by the government payment structure. I think evidence for this is that we had a researcher on loan and she said, on a different contract unrelated to what we were talking about, they had occasion to examine the skilled nursing facility area and found out that in the highest percentage of private pay, in any of the structures they were looking at, it was something like 5 percent or less.

So, clearly, we're looking at a 95 percent-plus government payment structure. And, obviously on the home health care, not only is it related to the DRGs but growth areas and, with very creative and talented people, not that the number of visits does not provide better quality and certainly quantity, but the fact that you pay for it might also have some connection to what they do and that's why we are here.

All that being said, what I am saying is to a very great extent, as far as I am concerned, these two industries were created by the government's willingness to pay in the way in which they paid. And, to the degree that HCFA and you folks look at ways of modifying the way that we're paying, you're not changing the game.

And that, I am wondering to what extent—going back to those original questions of a prospective payment system or doing away with some of the differences that are becoming more and more artificial on the basis of pay—as systems change, focusing on the beneficiary and creating a continuum of care drawn on, the basis of the needs of the patient rather than the payment structure from HHS, would give you a far better cost return than the current system or some of the suggested modifications of the payment system.

Now, I know that we have had hearings on the PACE and the others. Where are we in terms of fundamentally rethinking what we have created by virtue of the payment structure, that will not go away if we modify the payment structure, but rather fundamentally rethinking the way in which we approach beneficiaries and their needs?

Mr. NEWHOUSE. Well, I think your comments are right on target.

Chairman THOMAS. Except it's going to take 10 years to——

Mr. NEWHOUSE. That's the problem. I heard Congresswoman Johnson say we need a comprehensive system and I agree with that. And then, I heard her say, we need it now and I agreed with that but I can not really get there from here.

We just do not have the kind of case mix adjusters that we would like for this system.

Chairman THOMAS. Now, just stop right there, Mr. Newhouse.

Mr. NEWHOUSE. OK.

Chairman THOMAS. Because I want to pursue this for just a minute.

Mr. Cardin said and Mr. Vladeck agreed we ought to go ahead with changes in the areas that we can reach an agreement. Is the fact that we do not have a risk analysis model, that we do not have case-mix models, is that because it's simply not possible to do or is it because we've never, ever stressed the basics? The collection of data, with full protection in terms of individual's privacy, allows us to get a far broader look at what's going on, and as part of the receiving of payments from the government, a willingness to share data from any kind of a structured model out there, whether it be the fee-for-service or managed care or whatever—it seems to me if we had the ability, had committed ourselves to that fundamental agreement, to collect the data and begin to profile sooner, we would be closer to where we need to go.

Until and unless we do that, we still have significant holes in any kind of a structure that we create, including demonstration projects that are based upon that incomplete data. So, wouldn't the first step be as fundamental a collection of as broad a base data as we can get?

Mr. NEWHOUSE. Absolutely. And, you see that there's a strong recommendation to that effect in my testimony. The problem is that still does not help with the immediate future.

Chairman THOMAS. I understand.

Mr. NEWHOUSE. It's actually for that reason that I suggested a blend, where we kind of put a toe in the water, as it were, with an episode system that was not very well risk-adjusted, because it could not be, and a blend of that with some measure that also took account of use.

As we learned more, we could up the amount of weight in this blend on the episode-based payment.

Chairman THOMAS. I guess if you never begin, you never begin and the downside is if you think things can get worse, they can.

Mr. NEWHOUSE. Sometimes they can get worse even without your thinking they're going to get worse.

Chairman THOMAS. I think that's what happened over the last year.

I want to thank both of you for your continued commitment to try to provide us with the best tools available and I think we may need a couple of private sessions just to keep us up to speed as to where we might make the most meaningful changes, notwithstanding the climate, in which change is trying to be made.

Mr. NEWHOUSE. We're hoping to be of use to you as we go down the future path.

Chairman THOMAS. You have been and we appreciate that. Thank you very much.

Mr. NEWHOUSE. Thank you, Mr. Chairman.

Chairman THOMAS. I ask the next panel to come forward.

The panel consists of Stephen Holt, president and chief executive officer, Visiting Nurses Association of Greater Philadelphia; Margaret J. Cushman, president, VNA Health Care, Incorporated, from Hartford-Plainville, Connecticut; and Phillip I. Hoffman, chief financial officer, Outreach Health Services, Austin, Texas.

Mrs. JOHNSON. Mr. Chairman.

Chairman THOMAS. The gentlewoman from Connecticut.

Mrs. JOHNSON. While the panel is assembling, I would like to welcome Peg Cushman here. She has been one of the bright minds in home care services in our area and runs an outfit that has been very creative in both controlling costs and assuring quality and she still provides services to areas in which security is a very big issue and one of the few agencies in all of Connecticut that does that. She has been a real leader both in Connecticut and nationally and I am very pleased to have her with us today.

Chairman THOMAS. I want to thank all of the panelists for being with us. Any written testimony that you may have will be made a part of the record and you can inform us in the time that you have in any way that you see fit, beginning with Mr. Holt and then we'll move across the panel.

STATEMENT OF STEPHEN W. HOLT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSES ASSOCIATION OF GREATER PHILADELPHIA, ON BEHALF OF THE HOME HEALTH PPS WORK GROUP

Mr. HOLT. Thank you, Mr. Chairman.

My name is Stephen W. Holt and I am the president of the Visiting Nurses Association of Greater Philadelphia, which is one of the largest and oldest, not-for-profit providers of home health services in the country. In fact, we provided home health care services to patients in Philadelphia for 79 years prior to the inception of the Medicare Program. We are celebrating our 110th anniversary this year.

Thank you for the opportunity to speak to you today. I am also providing this testimony on behalf of the Home Health Prospective Payment System Work Group which is a coalition of 20 State and national home health associations dedicated to the prompt implementation of a prospective payment system for home health services under the Medicare Program, and one which provides incentives for high-quality services to be furnished in a cost-effective manner.

The Prospective Payment System Work Group includes representatives of all types of home health providers—nonprofit, proprietary, hospital-based, and free standing—from every region in the country and we have been working for over 18 months with Members of Congress and the administration on the development of prospective payment system as a substitute for copayments and bundling.

The Work Group is united with the National Association for Home Care on the following issues. We support prompt enactment and implementation of "The Revised Unified Home Health PSB Plan." We oppose copayments and bundling and we oppose the shift of home health coverage to part B of the Medicare Program.

The Prospective Payment System Work Group came together at the end of 1994 in response to a challenge issued by Members of Congress that if we did not believe copayments were sound public policy then the home health industry should come up with a better alternative. We accepted that challenge and began to work together with State associations to do so.

We consulted with and received encouragement from HCFA and we worked on a concentrated and continuous basis with both Republican and Democratic Members of Congress and the Subcommittee. We briefed White House staff and kept them apprised of the status of the plan's development. We also worked with the National Association of Home Care to make modification to the plan which would permit unified industry support.

The joint efforts of the Prospective Payment System Work Group and the National Association resulted in the unified industry PPS plan which served as the model for the Home Health Prospective Payment System which was passed by both houses of Congress as a part of H.R. 2491. Unfortunately that plan contained several flaws which were inserted in response to last-minute changes in scoring, among them the 45-day gap in service.

In addition, the HCFA raised concerns that the congressionally passed plan was too complex to be implemented by the effective date contained in the legislation. Accordingly, the prospective payment work group has worked intensively with NAHC over the past 7 months to develop the Revised Unified Prospective Payment System Plan which eliminates the flaws of the early legislation and addresses HCFA's implementation concerns.

We believe that the PPS plan that we have here is far better public policy than copayments for the following reasons. One, the PPS plan provides the mechanism for reducing the rate of growth in Medicare expenditures for home health services while preserving the opportunity for clinical decisions to be made by patients, physicians and providers based on medical necessity.

Two, the PPS plan creates incentives for home health agencies to become more cost-effective and efficient and rewards those that do.

Three, the PPS plan achieves true savings to the health care system.

Four, the PPS plan will reduce administrative costs, both for providers and the government, thereby, helping to preserve home health care as a low-cost treatment option.

Five, the PPS plan significantly reduces the opportunities and incentives for fraud, waste and abuse.

And six, the PPS plan has broad industry support. Never have I seen in my years in home care such collaboration among so many different groups and associations of the industry and never before have I seen them sign onto a plan which will affect every single home health agency in the United States.

By contrast, copayments curtail access to services regardless of medical necessity. They create no incentive for cost-effectiveness or efficiency. They shift a portion of the current inefficient system to patients and they increase administrative costs due to more complex billing.

They will not reduce and could increase the opportunities in the centers for fraud and abuse. And copays, too, are uniformly opposed by the industry and consumer groups.

We also believe the administration proposal to impose a prior hospitalization requirement on part A coverage and shift the bulk of the home health benefit to part B is seriously flawed for the following reasons.

It will add cost and confusion to the benefit because parts A and B have different billing, administrative, and appeals processes. It will reduce the value of the part A health benefit without any corresponding reduction in FICA taxes, which are earmarked for that benefit.

It will require Medicare beneficiaries, who have already paid for that coverage through FICA contributions, to pay for it again through taxes on fixed incomes, and we believe it is an accounting gimmick that does not result in true savings for the Medicare budget or the budget as a whole.

The industry is concerned it will leave the benefit vulnerable to a 20-percent copayment which applies to most part B services. Rather than further considering solutions such as copayments or the part B shift, we believe it is time to get on with implementing PPS for home health care.

This Subcommittee expressed its intent in OBRA 1987 and 1990 that home health reimbursement should be switched to PPS. After nearly 10 years with no progress, it is clear that we will never have a prospective payment system for home health unless it is especially mandated by Congress.

The Revised Unified Prospective Payment System Plan achieves significant savings, provides incentives for appropriate utilization and efficiency, and avoids curtailing access to medically necessary services. It also has extremely broad industry support.

We believe the home health industry has answered what you have challenged us to do and have answered the challenge and developed a better alternative to copayments and we ask that you and the president now do your part and enact and sign into law the Revised Unified Home Health Prospective Payment System Plan.

I would just like to add one thing. Mr. Vladeck did mention that he would like more information from the home care providers than he is currently receiving in order to move forward with PPS and we would certainly be willing to meet with he or his staff to determine what this additional information is.

Thank you very much for your attention.

[The prepared statement and attachments follow:]

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

HEARING BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH

1100 Longworth House Office Building
Tuesday, July 23, 1996

Medicare Payment Policies for Home Health Agency and Skilled Nursing Facility Services

TESTIMONY OF STEPHEN W. HOLT

Mr. Chairman, my name is Stephen W. Holt. I am President and Chief Executive Officer of the Visiting Nurse Association of Greater Philadelphia, which is one of the largest and oldest not-for-profit providers of home health services in the country. We have been providing a comprehensive range of high quality home health services to citizens in the Greater Philadelphia area for more than 100 years.

I am also providing this testimony today on behalf of the Home Health PPS Work Group, which is a coalition of 20 state and national home health associations dedicated to the prompt implementation of a prospective payment system for home health services under Medicare that provides incentives for high quality services to be furnished in a cost effective manner. The PPS Work Group includes representatives of all types of home health providers (nonprofit, proprietary, hospital-based, and free-standing) from every region of the country who have been working intensively over the past 18 months with members of Congress and the Administration on the development of a prospective payment system for home health services as a substitute for copayments and bundling.

The PPS Work Group is united with the National Association for Home Care on the following issues:

1. we support prompt enactment and implementation of the **Revised Unified Home Health PPS Plan** (copy attached);

2. we oppose copayments and bundling; and

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3. we oppose the shift of home health coverage to Part B of the Medicare program.

The PPS Work Group came together at the end of 1994 in response to a challenge issued by members of Congress that, if the home health industry did not believe copayments were sound public policy, it should propose a better alternative. We accepted that challenge and began to design a prospective payment system which had a broad base of support among the state home health associations. We consulted with, and received strong encouragement from, the Health Care Financing Administration. We worked on a concentrated and continuous basis with both Republican and Democratic members of Congress and this Subcommittee. We repeatedly briefed White House staff and kept them apprised of the status of the plan's development. We also worked with the National Association for Home Care to make modifications to the plan which would permit unified industry support.

The joint effort by the PPS Work Group and NAHC resulted in a unified industry PPS plan which served as the model for the home health prospective payment system which was passed by both houses of Congress as part of H.R. 2491. Unfortunately, that plan contained several flaws which were inserted in response to last minute changes in scoring. In addition, the Health Care Financing Administration raised concerns that the Congressionally-passed plan was too complex to be implemented by the effective date contained in the legislation.

Accordingly, the PPS Work Group has worked intensively with the National Association for Home Care over the past seven months to develop the **Revised Unified PPS Plan,** which eliminates the flaws of the earlier legislation and addresses HCFA's implementation concerns by phasing in the plan over 24 months and by simplifying the first implementation phase.

We believe that the **Revised Unified PPS Plan** is far better public policy than copayments for the following reasons.

1. **The PPS plan** provides a mechanism for reducing the rate of growth in Medicare expenditures for home health services while preserving the opportunity for clinical decisions to be made by patients, physicians, and providers based on medical necessity.

2. **The PPS plan** creates incentives for home health agencies to become more cost effective and efficient and rewards those that do.

3. **The PPS plan** achieves true savings to the health care system.

4. **The PPS plan** will reduce administrative costs both for providers and the government, thereby helping to preserve home health as a low cost treatment option.

5. **The PPS plan** significantly reduces the opportunities and incentives for fraud, waste, and abuse.

6. **The PPS plan** has broad industry support, while there is unified opposition to copayments among both providers and consumers.

By contrast, copayments:

- curtail access to services **regardless** of medical necessity and have a particularly harsh effect on the frail elderly with low and fixed incomes (by declining home health services because of copayments, patients will deteriorate and land back in the hospital or nursing home);

- create no incentive for cost effectiveness or efficiency but, rather, create an incentive for higher utilization to offset increased bad debt;

- shift a portion of the current inefficient system to patients, the Medicaid programs, or other health insurance programs;

- increase administrative costs due to more complex billing requirements and bad debt; and

- will not reduce, and could increase, the opportunities and incentives for fraud and abuse.

We also believe that the Administration's proposal to impose a prior hospitalization requirement on Part A coverage and shift the bulk of the home health benefit to Part B is seriously flawed for the following reasons:

- it will add cost and confusion to the home health benefit, because Parts A and B have different billing, administrative, and appeals processes and procedures;

- it will create an incentive for unnecessary hospitalizations;

- it will reduce the value of the Part A health benefit without any corresponding reduction in the FICA taxes which are earmarked for that benefit;

- it will require Medicare beneficiaries who have already paid for that coverage through FICA contributions to pay for it again through taxes on fixed incomes;

- it is an accounting gimmick that does not result in true savings nor does it provide incentives for more cost effective home health services; and

- it will leave the home health benefit vulnerable to the 20% copayment which applies to most Part B services.

Rather than further considering false solutions such as copayments or the "Part B shift," we believe it is time to get on with implementing prospective payment for home health care. This Subcommittee expressed its intent in OBRA '87 and '90 that home health reimbursement should be switched to prospective payment.[1/] After nearly ten years with no progress, it is clear that we will never have a prospective payment system for home health unless it is expressly mandated by Congress.

The **Revised Unified PPS Plan** achieves significant savings, provides incentives for appropriate utilization and efficiency, and avoids curtailing access to medically necessary services. It also has extremely broad industry support.

The home health industry has done what you asked us to do -- we have developed a better alternative to copayments. We ask you and the President to now do your part -- enact and sign into law the **Revised Unified Home Health PPS Plan.**

I would be glad to answer any questions.

1/ See § 4027(c) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) and § 4207(c) of the Omnibus Reconciliation Act of 1990 (Public Law 101-508).

Revised Unified Proposal for a Prospective Payment System for Medicare Home Health Services

Legislative Language

Approved by the Joint Policy Committee of
The National Association for Home Care
and
The PPS Work Group

July 12, 1996

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Revised Unified Proposal for PPS for Medicare Home Health Services
Proposed Legislative Language
7-12-96

CHAPTER 1–PAYMENTS FOR HOME HEALTH SERVICES

SEC. 8601. PAYMENT FOR HOME HEALTH SERVICES.

IN GENERAL- Title XVIII (42 U.S.C. 1395x et seq.), as amended by section 8102, is amended by adding at the end the following new section:

'PAYMENT FOR HOME HEALTH SERVICES

'SEC. 1894. (a) IN GENERAL- Notwithstanding section 1861(v) the Secretary shall provide for payments for home health services in accordance with a prospective payment system as follows.

'(1) PER VISIT PAYMENTS- Subject to subsection (c), the Secretary shall make per visit payments beginning within six months after the date of enactment and on a uniform implementation date to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, under any other contracting or consulting arrangement, or otherwise).

'(2) TYPES OF SERVICES- The types of home health services described in this paragraph are the following:

'(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

'(B) Physical therapy.

'(C) Occupational therapy.

'(D) Speech-language pathology services.

'(E) Medical social services under the direction of a physician.

'(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

'(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF SERVICE-

'(1) IN GENERAL- The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) for each type of home health service described in subsection (a)(2).

Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

'(2) NATIONAL PER VISIT PAYMENT RATE- The national per visit payment rate for each type of service described in subsection (a)(2)–

'(A) for fiscal year 1997, is an amount equal to the national average amount reimbursed per visit under this title to home health agencies for such type of service including medical supplies during the most recent 12-month cost reporting period ending on or before December 31, 1994, updated by the home health market basket percentage increase for each year prior to implementation; and

'(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year.

'(3) PAYMENTS ABOVE PER VISIT RATES-

'(A) A home health agency may elect to receive per visit payments in excess of the per visit payment rate under paragraph (1) up to the per visit payment limit if such provider can demonstrate that it can reasonably expect to incur such costs and that total payments will not exceed the agency's aggregate limit under subsection (c). The Secretary shall further provide for exemptions, exceptions and adjustments to the per visit payment limit of this section on the same basis as are provided under subsection (c)(3) with respect to the limitations on final payment.

'(B) For fiscal year 1997, the per visit payment limit is calculated as established by section 1861(v)(1)(L). For each subsequent year, the payment limit is equal to the limit for the preceding year increased by the home health market basket index.

'(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE- For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for the fiscal year.

'(c) AGGREGATE LIMITS-

'(1) PHASE I AGGREGATE LIMIT-

'(A) IN GENERAL- Beginning _____ and ending no later than 24 months after implementation, except as provided in paragraph (4), a home health agency may not receive aggregate per visit payments under subsection (a) for a year in excess of an amount equal to the following product:

'(i) The number of unduplicated patients during the year; multiplied by

'(ii) the per patient limit determined for such year.

'(B) ESTABLISHMENT OF PER PATIENT LIMITS-

'(i) For the initial year, the annual per patient limit shall be established through a blend of 75 percent of the agency-specific per patient base year reasonable cost with 25 percent of the census region for the area in which a home health agency is located per patient annual base year reasonable cost, calculated from the fiscal year 1994 cost per visit updated by the home health market basket percentage increase to the year for which the limit applies multiplied by fiscal year 1995 per unduplicated Medicare patient visit utilization.

'(ii) Beginning 12 months after application of the limitation required under subsection (i), the limitation shall be calculated through a blend of 50% agency specific and 50% of the census region per beneficiary annual base year reasonable cost updated by the home health market basket index to the year for which the limit applies, multiplied by the FY95 per unduplicated Medicare patient visit utilization.

'(iii) For new providers and those without agency-specific base year data necessary for the calculation under subparagraphs (i) and (ii), the per patient limit shall be equal to the mean of these limits applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name may not be considered new providers for payment purposes.

'(2) PHASE II AGGREGATE LIMITS-

'(A) IN GENERAL- Beginning _____ and ending no later than implementation of episodic prospective payment under paragraph (h), except as provided in paragraph (3), a home health agency may not receive aggregate per visit payments under subsection (a) for a year in excess of an amount equal to the sum of the following:

'(i) The sum of: the number of episodes for each case-mix category for which the agency receives payments during the payment year, as described

in subsection (2)(B) and (C), multiplied by the per episode limit determined for each such case-mix category for such payment year; and

(ii) the number of unduplicated patients receiving services beyond 120 days during the year multiplied by the per patient limit for services provided after 120 days as provided under subsection (2)(E).

'(B) ESTABLISHMENT OF PER EPISODE LIMITS FOR FIRST 120 DAYS-

'(i) IN GENERAL- The per episode limit for a payment year for any case-mix category for the area in which a home health agency is located (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) is equal to–

'(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1995, adjusted by the case-mix adjustment factor determined by clause (ii) for the fiscal year involved; multiplied by

'(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

'(ii) DETERMINATION OF AREA- In the case of an area which the Secretary determines has an insufficient number of home health agencies to establish an appropriate per episode limit, the Secretary may establish an area other than the area used to determine the area wage under section 1886(d)(3)(E)) for purposes of establishing and appropriate per episode limit.

'(C) CASE-MIX CATEGORY- For purposes of this paragraph, the term "case-mix category" means each of the 18 case-mix categories established under the Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop and apply a more accurate methodology for determining case-mix categories subject to prior public notice and comment under 5 U.S.C. § 553.

'(D) EPISODE-

'(i) IN GENERAL- For purposes of this paragraph, the term "episode" means the continuous 120-day period that–

'(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

'(II) is immediately preceded by a 45-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

'(ii) PRORATION OF EPISODE LIMIT SPANNING PAYMENT YEARS-The Secretary shall provide for such rules as appropriate to prorate episode limits under this paragraph which begin during a payment year and end in a subsequent payment year.

'(E) ESTABLISHMENT OF A PER PATIENT ANNUAL LIMIT FOR SERVICES PROVIDED AFTER 120 DAYS-

'(i) The per patient limit for services provided after 120 days shall be calculated through a blend of 50% of the agency-specific per patient reasonable cost with 50% of the census region per patient reasonable cost, calculated from the fiscal year 1994 cost per visit updated by the home health market basket percentage increase multiplied by fiscal year 1995 per unduplicated Medicare patient visit utilization of services after 120 days.

'(ii) The limitation shall represent fiscal year 1994 costs per visit updated by the home health market basket index multiplied by fiscal year 1995 annual per unduplicated Medicare patient visit utilization.

'(iii) For new providers and those without agency-specific base year data necessary for the calculation under subparagraphs (i) and (ii), the per patient limit shall be equal to the mean of these limits applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name may not be considered new providers for payment purposes.

'(3) EXEMPTIONS AND EXCEPTIONS- The Secretary shall provide for an exemption from, or an exception and adjustment to, at the request of the home health agency, the methods under this section for determining payment limits where events beyond the home health agency's control or extraordinary circumstances, including the case mix of such home health agency, create reasonable costs for a payment reporting period which exceed the payment limits. The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such methods, as the Secretary deems appropriate, as determined by the Secretary. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 120 days after receiving a completed application from the home health agency for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied. The total expenditures for exemptions and exceptions shall not exceed the cumulative share of overall program savings achieved for the Secretary which represent 50% of the difference between aggregate per visit payments and the aggregate limits.

'(4) RECONCILIATION OF AMOUNTS-

'(A) PAYMENTS IN EXCESS OF LIMITS- If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

'(B) SHARE OF SAVINGS-

'(i) COMPUTATION- If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in an amount less than the amount determined under paragraphs (1) and (2) with respect to such home health agency for such fiscal year and, with respect only to sections (c)(1) and (c)(2)(E), the home health agency has an average payment per unduplicated Medicare patient at or below 125% of the census region rate (as defined in section (c)(1)(B) and (c)(2)(E), whichever is applicable), the Secretary shall pay such home health agency a payment equal to 50 percent of the difference between such amounts except that the payment may not exceed 10 percent of the aggregate per visit payments up to the aggregate limit made to the agency for the year.

'(ii) INSTALLMENT PAYMENTS- The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated payment that the agency would be eligible to receive with respect to such fiscal year.

'(d) MEDICAL REVIEW PROCESS- The Secretary shall implement a medical review process for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are made under this section to ensure that such individuals receive appropriate home health services.

'(e) ADJUSTMENTS-

'(1) IN GENERAL- The Secretary shall provide for appropriate adjustments to payments to a home health agency under this section to ensure that the agency does not engage in the following for the purposes of circumventing the limits:

'(A) discharging patients to another home health agency or similar provider;

'(B) altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title.

'(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES-

'(A) DEVELOPMENT OF SYSTEM- The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than one home health agency.

'(B) ADJUSTMENT OF PAYMENTS- The Secretary shall adjust payments under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

'(3) MONITORING LOW COST CASES-

'(A) IN GENERAL- The Secretary shall develop and implement a system designed to monitor significant changes in the percentage distribution of low-cost and high cost patients for which home health services are furnished by the agency over such percentage distribution determined for the agency under subparagraph (B).

'(B) DISTRIBUTION- The Secretary shall profile home health service to determine the distribution of all episodes by length of stay for the purpose of determining regional and national trends.

'(C) LOW-COST AND HIGH-COST PATIENTS- For purposes of this paragraph, the Secretary shall define a low-cost and high-cost patient in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

'(D) The Secretary shall report to Congress on an annual basis findings and recommendations for ensuring access to appropriate home health services.

'(f) SPECIAL RULE FOR CHRISTIAN SCIENCE PROVIDERS-

'(1) PAYMENT PERMITTED FOR SERVICES- Notwithstanding any other provision of this title, payment shall be made under this title for home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts, and are certified for purposes of this title under criteria established by the Secretary, in accordance with a payment methodology established by the Secretary.

'(2) EFFECTIVE DATE- Paragraph (1) shall apply to services furnished during cost reporting periods which begin after the date on which the Secretary establishes the payment methodology and the certification criteria described in paragraph (1)

'(g) REPORT BY MEDICARE PROSPECTIVE PAYMENT REVIEW COMMISSION- During the first 3 years in which payments are made under this section, the Medicare Prospective Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

'(1) Case-mix and volume increases.

'(2) Quality monitoring of home health agency practices.

'(3) Whether providers of service are adequately reimbursed.

'(4) On the adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

'(5) The appropriateness of the methods provided under this section to adjust the aggregate limits and annual payment updates to reflect changes in the mix of

services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

'(6) The geographic areas used to determine the per episode and per patient limits.'

(h) 'EPISODIC PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES-

'(1) The Secretary shall provide for payments for home health services in accordance with an episodic prospective payment system, in accordance with subparagraphs (2) through (9).

'(2) The Secretary shall develop an episodic prospective payment system taking into consideration, first, the data and processes from section 1894(c)(2) that have proven valid and reliable; and second, the degree of disruption resulting from changing the payment system.

'(3) The per episode amount under such a system shall include all services covered and paid under the Medicare home health benefit as of the date of the enactment of Sec. 1894, including medical supplies. In defining an episode of care, the Secretary shall consider an appropriate length of time for an episode the use of services and the number of visits provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current data available to the Secretary and shall include consideration of the cost of new regulatory requirements, changes in technology and new care practices.

'(4) The Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

'(5) The episode payment amount shall be adjusted annually by the home health market basket index. The labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.

'(6) The Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

'(7) A home health agency shall be responsible for coordinating all care for a beneficiary.

'(8) Such a system shall be developed with input from and coordination with representatives from the home health services industry and consumers of home health services.

'(9) The Secretary shall submit a proposal for a prospective payment system consistent with subsections (1) through (8) to Congress within four years of enactment and implementation of the amendments to section 1894 of the Social Security Act. Implementation of an episodic prospective payment system shall be effective no earlier than one year and no later than 18 months subsequent to enactment of such a system.

'(i) Within 60 days of enactment of amendments made by sections (a) through (h), the Secretary shall initiate the development of a data base upon which a fair and accurate case mix adjustor, as required by sections (c)(2)(C) and (h)(3), can be developed and implemented. The data base must:

'(1) be capable of linking case mix data with cost and utilization data;

'(2) contain data from HCFA Form 485 and UB-92;

'(3) contain additional data elements sufficient to support the case mix categories in section (c)(2)(C);

'(4) contain any additional data elements determined necessary by the Secretary in consultation with representatives of the home health industry.

'(j) APPEALS- Section 1878(a) of the Social Security Act is amended to add at the end of "in accordance with subsection (h)" the following:

"any home health agency which has received payment pursuant to section 1894 may obtain a hearing by the Board, with respect to such payment,"

SEC. 8602. Section 1154 of the Social Security Act is amended to add the following new subsections (g) and (h):

'(g) each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of the level of care and quality of services provided individuals receiving home health services pursuant to section 1812(a)(3) and 1832(a)(2)(A)(i).

'(1) If -

'(A) a home health agency has determined that a patient does not meet the conditions for payment of home health services under section 1814 or section 1833, or

'(B) the home health agency has determined that a patient no longer requires home health services, or

'(C) the home health agency has determined that a patient requires a level of care which is inconsistent with the care prescribed by the patient's attending physician, or

'(D) the patient has been authorized by the home health agency to receive a level of care less than that considered by the patient as appropriate to meet the patient's needs, then the home health agency shall provide the patient (or the patient's representative) with a notice (meeting the conditions of prescribed by the Secretary under section 1879) of the determination.

'(2) If-

'(A) the patient (or patient's representative) -

'(i) has received a notice under paragraph (1), and

'(ii) requests the appropriate peer review organization to review the determination,

'then, the organization shall conduct review under subsection (a) of the validity of the home health agency's determination and shall provide notice (by telephone and in writing) to the patient or representative and the home health agency and attending physician involved of the results of the review. Such review shall be conducted regardless of whether the home health agency will charge for continued home health services or whether the patient will be liable for payment for such continued care.

'(B) If a patient (or a patient's representative) requests review under subparagraph (a) while the patient is still a patient of the home health agency and not later than noon of the first working day after the date the patient receives the notice under paragraph (1) then -

'(i) the home health agency shall provide to the appropriate peer review organization the records required to review the determination by the close of business such first working day, and

'(ii) the peer review organization must provide the notice under subparagraph (a) by not later than one full working day after the date the organization has received the request and such records.

'(3) If -

'(A) a request is made under paragraph 2(A) not later than noon of the first working day after the date that the patient (or patient's representative receives the notice under paragraph (1), and (b) the conditions described in section 1879(a)(2) with respect to the patient or representative are met, the home health agency shall not charge the patient for home health services furnished before noon of the day after the date the patient or representative receive notice of the peer review organization's decision.

'(4) In any review conducted under paragraph (1) or (2), the organization shall solicit the views of the patient involved (or the patient's representative).

'(h) The utilization and quality control peer review organization shall monitor the delivery of home health services in a manner which includes, but is not limited to, a review of home health agencies that present significant variation in utilization.'

SEC. 8603. Section 1155 of the Social Security Act is amended to add the following at the end:

'"Notwithstanding the foregoing, any beneficiary receiving home health services subject to review under section 1154(g), and the provider, who is dissatisfied with a determination, shall be

entitled to a hearing by the Secretary and to judicial review of any final determination to the same extent as provided under Section 1869 of the Social Security Act.

SEC. 8604. Section 1816(j) of the Social Security Act is amended to remove the following:

'"home health services,"

SEC. 8605. RETROACTIVE REINSTATEMENT OF PRESUMPTIVE WAIVER OF LIABILITY.

'(a) Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "December 31, 1995" and inserting "upon implementation of a prospective payment system for home health care services, under section 1894(h).'

'(b) The second sentence of Section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking "December 31, 1995" and inserting "upon implementation of a prospective payment system for home health care services under section 1894(h).'

Chairman THOMAS. Thank you, Mr. Holt.
Ms. Cushman.

STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT, VNA HEALTH CARE, INC., HARTFORD-PLAINVILLE, CONNECTICUT; ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. Thank you, Mr. Chairman for the opportunity to present testimony today on the important subject of prospective payment. I will just give the highlights of my written testimony and ask that it be submitted for the record.

I am Peg Cushman. I am the president of VNA Health Care in Hartford-Plainville, Connecticut, which incidentally is 95 years old this year. It has been around for a while.

I also chair the government affairs committee for the National Association for Home Care and serve on the Prospective Payment Task Force.

The National Association for Home Care is deeply appreciative of the support of this Committee and its members and the attention home care prospective payment has received in this Congress. We thank you for your leadership, as well, in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from part A to part B of Medicare.

I wish to place NAHC on record as adamantly opposed to the administration's proposal to transfer a portion of Medicare's home health benefit from part A to part B. This transfer proposal would have very serious consequences for Medicare home health recipients.

We also want to thank you, Mr. Chairman, and Members of the Committee for your support on the extension of the presumptive waiver in the budget reconciliation package that was reported out of this Committee and a number of Members of this Committee, including Representatives Johnson, Kennelly, Jacobs, Cardin, Portman, English, and McNulty have written the administration or introduced legislation on its behalf.

Congress has before it a unique opportunity to improve the Medicare home health benefit in a way that the unified home care industry supports and will stand behind. Our goal is to develop a prospective payment plan that would provide cost-effective quality care to beneficiaries, use the best that both Republican and Democratic prospective payment plans have to offer, address concerns raised about previous plans meet deficit reduction requirements, substitute for home care copays and bundling, and finally, address HCFA's concerns about implementation issues.

The revised unified prospective payment plan represents the most advanced thinking in this field that's been done in developing a prospective payment system and it's a substantial improvement over the Medicare current cost-based reimbursement system.

Let me be very direct in the context in which we raise this PPS proposal. Last year, Congress proposed sizable savings from the Medicare home care program, a portion of which was from home care. And since we found copayments and bundling offensive to us, we were challenged to develop a more acceptable way of achieving the required savings. We propose this prospective payment system

in that spirit and as an alternative to the copays, bundling, and other methods for deficit reduction.

Our goal in the home care community in proposing prospective payment is to manage the growth of the Medicare home health expenditures in a method that produces efficiency and preserves access and quality of care for beneficiaries through the development of an implementation of an episodic prospective payment system.

PPS offers many advantages over the current cost-based reimbursement system. The current system is complex. It is costly to administer and the amounts paid are subject to disallowance recoupment long after services are provided. It offers no incentives for providers to have efficiency in their provision of services.

By contrast, prospective payment provides market-like incentives that encourage the efficient provision of services and provides financial incentives for home care agencies to reduce both visit and episodic costs, resulting in Medicare savings without restricting beneficiary access to high-quality home care services. It properly places the burden of efficiency on providers, not beneficiaries.

Our unified proposal calls for a three-phase approach to achieving episodic prospective payment starting with an interim plan that uses existing data to put in place prospectively set per visit payment rates subject to caps, and moves within 5 years to an episodic prospective payment system with a case mix adjuster that distinguishes the cost of providing services to different types of patients.

This plan would give home care providers incentives to reduce costs and increase efficiency by allowing them to keep a portion of the difference between the total per visit payments in the agencies' annual aggregate caps. This provision differs from hospital prospective payment system in that it only would offer a portion of the savings to the agency as opposed to the entire thing.

We believe through our work with Price Waterhouse, that this proposal will present savings roughly equivalent to those offered under the administration's proposal and have built in to the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about the assumption CBO has employed in scoring past PPS proposals, as earlier referenced by Representative Johnson. Under the CBO's offsets in the past, a PPS proposal scored at $14.2 billion in savings over 7 years, as was the proposal in the BBA, would actually reduce Medicare home health expenditures by $42.6 billion over 7 years, three times the amount scored.

Never, to our knowledge, has such a high scoring been employed for dramatic assumptions of gaming. An offset of this magnitude would make it almost impossible for home care to offer savings without inflicting great harm in the services available to beneficiaries.

We greatly appreciate the interest that Mrs. Johnson and others on the Committee have demonstrated in this issue. We appeal to the Committee for help in encouraging CBO to employ realistic assumptions that do not penalize providers and patients.

Thank you, again, Mr. Chairman, for the opportunity to testify.

[The prepared statement follows:]

**STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT,
VNA HEALTH CARE, INC.
ON BEHALF OF
THE NATIONAL ASSOCIATION FOR HOME CARE**

Mr. Chairman,

Thank you for the opportunity to present testimony today on the important subject of prospective payment for home care. My name is Margaret J. Cushman. I am the President of VNA Health Care in Hartford-Plainville, Connecticut. I also chair the Government Affairs Committee of the National Association for Home Care (NAHC), as well as serve on the NAHC Prospective Payment System (PPS) Task Force.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies, like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

The National Association for Home Care thanks you, Mr. Chairman, and Members of the Committee for the support you have expressed for PPS for home care, as well as your leadership in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from Part A to Part B of Medicare.

NAHC is deeply appreciative of the support and attention PPS for home care has received from this Committee and in this Congress. We have been advocating such a system for more than a decade. Congress, too, has been pushing the Administration for development of a PPS for home care for many years. We were very pleased that proposals to implement such a system were included in the balanced budget plans offered by both parties, and a PPS plan was passed by the full Congress as a part of HR2491, the Seven Year Balanced Budget Act (BBA).

I'd like to ask permission, Mr. Chairman, to have my full written statement, along with the following attachments, included in the hearing record:

- a resolution in support of the industry's Revised Unified PPS Plan signed on to by 50 state home care associations,
- a detailed description of the industry's Revised Unified Plan, and
- a side-by-side comparison of current law with the PPS provisions of the BBA, HR2530, and the industry's new Revised Unified Plan.

Congress has before it a unique opportunity to improve the Medicare home care benefit in a way that the home care industry supports and will stand behind. The Revised Unified PPS plan incorporates the best elements of the home care PPS provisions in the BBA passed by Congress and HR2530. Our goal was to develop a PPS plan that 1) the home care industry could support, 2) would use the best that both the Republican (BBA) and Democratic (HR2530) plans had to offer, 3) would address concerns raised about the PPS plans in both the BBA and HR2530, 4) would accommodate deficit reduction requirements, 5) would substitute for home care copays and bundling, and 6) would address HCFA's concerns about feasibility of implementation on a timely basis.

The Revised Unified PPS Plan represents the most advanced thinking that's been done in developing a PPS plan. It also represents a substantial improvement over the current Medicare cost-based reimbursement system.

Let me be very direct regarding the context in which we are offering this PPS proposal. In 1995, Congress proposed sizable savings from the Medicare program, a portion of which was to come from home care. Since the industry found copayments and bundling unacceptable, Congress challenged us to develop a more acceptable way of achieving the required savings. This PPS proposal was developed as an alternative to home care copays, bundling, and other onerous ideas, and that is the context in which we are offering it today.

Growth in Home Care

Home care encompasses a broad spectrum of both health and social services that can be delivered to recovering, disabled or chronically ill persons in their homes. These services include the traditional core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, and medical social services.

Generally home care is appropriate whenever a person needs health care assistance that cannot be easily or effectively provided solely by a family member or friend on an ongoing basis for a short or long period of time. There are many situations and conditions for which home care services are especially appropriate. Technology advancements mean that every day more people are able to be cared for effectively and efficiently at home even if they have illnesses that, at one time, were only treatable in hospitals or institutions.

The home health benefit has been a maturing benefit for most, if not all, of its existence in the Medicare program. In Medicare's earliest years, home health expenditures amounted to only about one percent of the total. Today, approximately 8.7% of Medicare payments are made for home health services. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1995, approximately 3.6 million Americans received home health services, representing an estimated $15.9 billion in Medicare spending. Much of the increase over time can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services.

Home health growth, however, is beginning to moderate and it is expected to continue to fall to more modest levels in the next few years. The change in the number of home health visits has dropped from a 25% increase in 1993 to a 13.7% increase in 1995. The HCFA Office of the Actuary expects this rate to continue to slow, from 10.5% in 1996 to 7.3% in 1997, and to steadily decrease to around 2.6% through the year 2000.

The home health benefit increases that occurred in the 1989-1992 period were almost double the 23.5 percent average experienced over the life of the Medicare program but have already begun falling to lower rates. Evidence indicates this peaking is temporary and has been influenced by several recent events.

Coverage Clarification. In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a "chilling effect" in which some Medicare covered claims were diverted to Medicaid and regrettably some patients went without care. This "denial crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrariness had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25 percent) came in 1989 when the clarifications were announced; and an even larger increase took place (50 percent) in 1990, the first full year the new policies were in effect. However, growth in the number of visits is beginning to return to more modest levels.

Personnel Shortage. Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 8,100 in 1995.

New Legislative Requirements. In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA-87 home health aide training

and competency testing requirements and the Clinical Laboratory Improvement Amendments of 1988. The costs associated with these changes are reflected in visit charges.

New Administrative Changes. The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.

The growth in the Medicare home health benefit, however, is moderating and can be expected to fall to more single digit modest levels in the next two years. A number of factors will cause continued, albeit moderate growth in home health utilization. Foremost among these is the pursuit of cost-effective alternatives to institutional care.

Cost Effectiveness. Home health has moved well beyond its traditional boundaries, making it possible for patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment.

An Aging Population. The aging of the U.S. population will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85 are three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access. Access to in-home services has also improved over the years, as more home health agencies choose to participate in the Medicare program. In 1967, there were 1,753 agencies certified for Medicare purposes. By 1980, that number had nearly doubled to 2,924. As of January 1995, a total of 8,100 agencies were providing services under the program. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference. The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38 percent of Americans knew about home care; by 1988, over 90 percent of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A poll conducted in 1992 by Lou Harris and Associates, found that the American public supports home care by a margin of 9 to 1 over institutional care. Nearly 82 percent of all accredited medical schools now offer home health care in their curricula.

Technological Advances. Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Additional Factors. Litigation and workers' compensation claims are two additional factors that affect the cost of delivering home health services.

Reductions in home care spending are likely to result in greater Medicare expenditures for hospital inpatient and emergency care, physician services, and nursing home care. Home health care serves as the safety net for patients who are discharged from acute and rehabilitation hospitals after shorter lengths of stay.

Advantages of PPS

PPS offers numerous advantages to the Medicare program over the current cost-based reimbursement methodology. Under current law, home health agencies are reimbursed for the allowable costs which they incur in caring for Medicare patients up to a cap. Cost reimbursement, however, has been criticized because it is complex and costly to administer,

because the amounts that are paid are subject to disallowance and recoupment long after the services have been rendered and because it offers no incentives for provider efficiency.

PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid these problems because payment rates would be established in advance.

PPS, by providing financial incentives for home care agencies to reduce both visit and total case costs, will achieve Medicare savings without restricting beneficiary access to high quality home care services. PPS properly places the burden to be efficient in the provision of care on providers and not beneficiaries. Alternatives to PPS, like copayments and bundling, create barriers to high quality home care services by increasing a beneficiary's out-of-pocket expenses and restricting access to post-acute care services.

Building on the BBA and HR2530

The Revised Unified PPS Plan builds on the home care PPS plans included in both the BBA and HR2530. In developing this revised plan, we endeavored to take the best elements of both bills. We also listened carefully to the concerns raised by home care providers about both plans, as well as concerns raised by HCFA regarding their ability to implement and administer the plans.

A key aspect of the PPS plan included in the BBA which remains at the heart of the new Revised Unified PPS Plan is the ability to manage the growth in volume of services provided to individuals through aggregate beneficiary caps. The plan would have moved home care toward adopting managed care principles and a more price conscious approach to health care delivery. The BBA built in incentives for home care providers to keep overall case costs as low and efficient as possible while still meeting patient needs.

The BBA would have moved Medicare home care away from cost-based reimbursement. HR2530 would have moved home care into an episodic PPS. Both of these landmark changes are adopted in the Revised Unified PPS plan.

NAHC's concerns with the PPS plan included in the BBA centered around 5 issues.

First, the episode limits were based on the cost of care provided for 120 days, but would have required home care agencies to provide up to 165 days of care for those limits.

Second, payment rates and limits would have been updated with the home health market basket index minus 2 percentage points.

Third, the BBA did not include a plan for developing and implementing a per-episode PPS, so the interim plan would have been in place for at least 7 years.

Fourth, the amount of time required before a new episode limit was recognized would have been increased from 45 days, as proposed by the industry, to 60 days.

Fifth, the bill's failsafe provision might have resulted in additional across the board savings if savings targets were not met.

NAHC was concerned with elements of HR2530 and the Administration's PPS Plan, as well. First, the plan would have retained cost-based reimbursement until October 1, 1999. While many home care providers have voiced the need for time to prepare for payment system changes, others are anxious to eliminate cost-based reimbursement and the problems with retroactive denials as soon as possible.

Second, the plan would have reduced cost limits to 105 percent of the median, an unacceptably high reduction.

Third, the plan lacked a case-mix adjuster. While the case-mix adjuster included in the BBA explains less than 10 percent of the variation in costs, it represents the best available today.

Fourth, the plan had the potential to penalize the most efficient home care providers by delaying implementation of the blended limit for 3 or more months.

Waiver of Liability

Also included in the BBA and closely linked to enactment of PPS was a provision to extend the presumptive status of the waiver of liability for home care, a provision of great importance to NAHC.

In 1972 the Health Care Financing Administration created a presumptive waiver of liability status for Medicare providers. Under the presumptive waiver, providers were presumed to have acted in good faith and were paid for services to a Medicare patient if their low error rate demonstrated a reasonable knowledge of coverage standards in their submission of bills. The presumptive waiver was later incorporated into legislation which after several extensions expired for home care and hospice on December 31, 1995.

The BBA would have extended the presumptive waiver for home care until October 1, 1996, when the Act provided that a prospective payment system would be established for home care. When the Act was vetoed, the presumptive status of the waiver expired.

To make matters worse, HCFA has imposed a system which presumes fraud by assuming providers knew their claims would not be covered, forcing providers to appeal each claim. Reconsideration of claims costs the federal government approximately $400 per claim, and costs providers in the range of $150 for each claim, just to reach the point of requesting waiver protection. If the dispute moves to the Administrative Law Judge level, the federal government and the provider each incur likely costs of $1,000 per claim reviewed.

In order for a home care agency to be compensated under the waiver presumption, its overall denial of claims rate had to be less than 2.5% of the Medicare services provided. Any agency that exceeded this limit was not reimbursed under the presumptive waiver. This requirement forced agencies to use due diligence in determining eligibility and coverage.

Given the vague application of constantly changing regulations, guidelines, and directives, it is difficult enough for home health agencies to be 97.5% correct in their determinations of eligibility. The high number of claims denials that are reversed (25% at reconsideration stage and 70% at the Administrative Law Judge level) shows that coverage decisions are not as clear cut as HCFA asserts. At a time when sicker patients are admitted to home care following earlier hospital discharges, coverage questions are more complex, and the buffer zone of the waiver presumption is particularly important.

Congress enacted the presumptive waiver to encourage home health agencies to provide services to Medicare patients, and to save on the considerable administrative time and expense of handling appeals in cases where agencies are delivering services in the good faith belief that the services are covered by Medicare. In the absence of the waiver presumption, agencies will have no recourse but to reject clients if there are any doubts about coverage. The waiver presumption for home health agencies and hospices should be permanently reinstated and made retroactive to January 1, 1996.

We want to thank you, Mr. Chairman, and Members of this Committee for your support of the extension of the presumptive waiver in the budget reconciliation package that was reported out of the Committee. We would like to extend a special thanks to Representatives Johnson, and Kennelly, for their advocacy in behalf of extending the waiver. Thanks also to Representative Jacobs for introducing HR3678, a bill to extend the home health and hospice waivers, and to Representatives Cardin, Portman, English, Jacobs, and McNulty for introducing the Medicare Hospice Benefit Amendments of 1996 (HR3714) that would permanently extend the presumptive waiver of liability for hospice.

Revised Unified PPS Plan

The Revised Unified PPS Plan that we are testifying in support of today is a modification of the

original unified plan submitted to Congress in 1995 as an alternative to Congressional movement to impose copays on Medicare home care services or to bundle home care payments into payments to hospitals.

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this without jeopardizing beneficiary health and safety. Our goal was to develop an episodic system which would:

- o be developed cooperatively by HHS, the industry, and Congress,
- o be acceptable to the industry,
- o include extended care,
- o be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation,
- o be implemented only after Congressional approval,
  include adjustments for new requirements (such as OSHA)
- o or changes in technology or care practices,,
- o be based on a case-mix adjuster that reflects the differences in cost for different types of patients,
- o prevent the imposition of home care copays, bundling, or other benefit limits,
- o implement a per-episode PPS as soon as possible, and
  do as little harm as possible to home care patients and
- o providers in implementing an untested system.

This plan, which represents months of work and refinement by the home care industry, calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case-mix adjuster and would require the development, within five years, of a per-episode PPS with a case-mix adjuster that adequately distinguishes the cost of providing services to various types of patients, using a three phase approach.

Phase 1 of the Plan would implement a prospectively set standard per visit payment with an annual aggregate per patient limit that applies to all visits. Phase 2 would put in place prospectively set standard per visit payments with an annual aggregate episode limit for days 1 - 120 and an annual aggregate per patient limit for visits after 120 days. Phase 3 puts in place a per-episode PPS.

This PPS plan would give home care providers incentives to reduce costs and increase efficiency through a provision in which they would be allowed to keep a portion of the difference between the total per visit payments and the agency's annual aggregate cap. This provision differs from the way PPS for hospitals was implemented, in which hospitals are allowed to retain the entire difference between the DRG payment rate and the cost of care. Under the revised unified PPS proposal, home care providers would be allowed to retain 50 percent of the difference, up to a cap, with the balance of the savings used for the exceptions process.

Scoring

NAHC has been working with the accounting firm of Price Waterhouse in reviewing the potential cost savings available through this proposal. We believe it to represent savings roughly equivalent to the savings offered under the Administration's PPS proposal and have built into the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about certain assumptions the Congressional Budget Office has employed in scoring PPS proposals for home care. In assessing the prospective payment proposal included in HR2491, CBO imposed a 66 2/3% offset that had the effect of dramatically reducing potential savings the proposal could have achieved. This offset reflects CBO's assumptions of behavioral changes on the part of home health care providers in response to this

proposal, as well as their assumption of the proposal's effectiveness.

CBO used this two-thirds offset to calculate net savings for the home health prospective payment provision, meaning that the sum of gross savings for each provision of the proposal was reduced by two-thirds. Under this offset, a proposal scored at $14.2 billion in savings over 7 years, as was the PPS proposal in the BBA, actually would reduce Medicare home health expenditures by $42.6 billion over 7 years, or three times the scored amount.

Never before, to our knowledge, has CBO employed such a dramatically high assumption of gaming. An offset of this magnitude is entirely unjustified and makes it much more difficult for home care to present a proposal offering necessary savings that does not inflict great hidden harm to home care beneficiaries.

We greatly appreciate the interest Mrs. Johnson and others on the Committee have demonstrated in this issue and we appeal to the Committee for help in encouraging CBO to employ realistic assumptions that do not penalize home care providers and patients.

History of PPS

NAHC has long supported the development of a prospective payment system for home care. NAHC championed the initial PPS demonstration legislation that Congress passed in 1983 as part of the Orphan Drug Act (P.L. 97-414). In that legislation, Congress required the Medicare program to test alternative reimbursement methodologies to determine the most cost effective and efficient way of providing care, including fee schedules, prospective payment, and capitation payments.

Following the passage of this legislation, the industry, through the National Association for Home Care, created its first Prospective Payment Task Force. When the demonstrations authorized under that legislation were held up in 1985 by the Office of Management and Budget, NAHC stepped in and partially funded the Georgetown University study on patient classification.

The U.S. Department of Health and Human Services (DHHS) did not undertake any serious effort to follow through with the study required in the 1983 legislation. Accordingly, the industry sought a stronger mandate from Congress.

With the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Congress required that DHHS design a prospective payment demonstration in a manner that would enable the Secretary to evaluate the effects of various methods of prospective payments (including payments on a per visit, per case, and per episode basis) on program expenditures, as well as beneficiaries' access to care. An interim report was required by Congress within one year after enactment of the legislation. A final report was due 4 years after enactment. The demonstration was set to begin no later than July 1, 1988.

The Health Care Financing Administration (HCFA) was unable to move the demonstration project forward on a timely basis and sought a delay from Congress. As part of the Medicare Catastrophic Protection Act of 1988, OBRA-87 was amended to modify the effective date from July 1, 1988 to April 1, 1989.

After nearly three years with limited effort by DHHS, Congress, at the request of the home health industry, once again intervened in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Congress directed HCFA to research and report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. DHHS was required to submit a report to Congress that included a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission was to analyze the DHHS proposal and report to Congress by March 1, 1994.

In developing this proposal, DHHS was required to:

(1) provide for appropriate limits on home care expenditures;

(2) account for changes in patient case-mix, severity of illness, volume of cases, and the development of new technologies and standards of medical practice;

(3) consider the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;

(4) address the varying wage-related costs among agencies; and

(5) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Ultimately, HCFA initiated a two phase demonstration project to study prospective payment for home health services. In Phase 1, HCFA experimented with a per visit prospective payment methodology. That project, which concluded in 1994, found limited effect on the behavioral actions of home health agencies and expenditure through the use of a per visit method of reimbursement.

Phase 2 of the demonstration project was initiated in March, 1995. Phase 2 is intended to study the behavioral reaction to a per episode based prospective payment system using a case-mix adjustor that classifies patients into one of eighteen categories. As the result of the weaknesses of the case-mix adjustor, explaining only 9.7% of variation in costs for various types of patients, HCFA limited the focus of the demonstration project to analyzing behavioral changes for participant home health agencies. It is expected that a final report will be issued on Phase 2 of the demonstration project in either 1999 or 2000.

NAHC is concerned that Phase 2 as it is currently constructed, will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. NAHC believes that the demonstration should be reoriented to deal with these case-mix problems now rather than set aside and left for some later time. Failure to take an accurate account of the medical acuity of an agency's patient caseload will result in inequitable payment levels that make it uneconomical to serve the most severely ill patients.

NAHC Positions on Alternatives to PPS

We would like to reiterate that this Revised Unified PPS Proposal, while an improvement over the current cost-based reimbursement system, is being offered solely in the context of deficit reduction as an alternative to other home care savings proposals.

Some of the proposed savings alternatives, including shifting some home care from Medicare Part A to Part B, placing copayments on Medicare home health visits, and bundling home care payments into hospital DRGs or other provider payments, would have serious detrimental effects on the 3.5 million Americans who rely on quality home health care. Moreover, these proposals could severely limit access to home care, limiting health care choices for our Nation's elderly and disabled to more costly institutions.

We were extremely gratified that in the BBA, the Committee abandoned home health copayments and bundling in favor of a prospective payment system (PPS) as a way to ensure the efficient delivery of home care services.

A to B Shift

The Administration has proposed, as part of its plan to restore fiscal integrity to the Medicare Hospital Insurance Trust Fund, to transfer a portion of Medicare's home health benefit from Medicare Part A to Part B. NAHC greatly appreciates your leadership, Mr. Chairman, as well as the support from other Members of this Committee, for maintaining home care as a Part A benefit.

Such a shift would have very serious consequences for Medicare home health recipients. Part A services are available to all individuals who qualify for the Medicare program. Medicare Part B is an optional program that individuals can join only through payment of monthly premiums.

In addition to de-emphasizing the importance of home care by eliminating its status as an entitlement, this shift would make a major portion of the benefit dependent on taxpayer financing. As a result, Medicare home health beneficiaries could be subjected to additional coverage restrictions including copayments, deductibles and other measures that would further reduce the benefit. This proposal would decrease cost-effective medical benefits to millions of Americans, many of whom have already contributed to the Medicare system, at a time when the need for home care services is growing.

Copays

Copayments on Medicare home health services also have been discussed by Congress as a way to increase beneficiary accountability and to control home health utilization. Imposition of a home health copayment would create a new "sick" tax on the most frail and vulnerable elderly and disabled Americans -- those who could least likely afford it. Moreover, the policy is "penny wise and pound foolish" and may end up costing the Medicare program more since patients who cannot afford the copayment may defer necessary services, resulting in subsequent nursing home placements, hospitalization or care from other more costly institutions.

Medicare home health copayments do not take into account the in-kind contributions made by Medicare home care patients toward the cost of their care. When Medicare pays for the care of an individual in a nursing home or hospital, it also pays its share of the cost of the building, maintenance, overhead, food, heat, and other significant costs, none of which Medicare incurs with home care. In addition, home care patients, families, and friends make significant contributions to care through "sweat equity." Individuals who receive no Medicare reimbursement provide significant care to Medicare home care patients, as home care nurses train family members and friends to provide care at home.

When the home health benefit was first enacted in 1965, it contained a copayment requirement. This copayment was later dropped because it cost Medicare more to collect in administrative costs than it saved the program. Copayments were a bad idea then, they are a bad idea now.

Bundling

Bundling home care payments into other provider payments would severely compromise both the quality and accessibility of home care available to Medicare beneficiaries in a number of ways. First, many hospitals have limited experience with the provision of non-hospital post-acute care services. Second, home care payments based on DRG rates simply would not meet patients' needs.

Bundling would also vastly increase the administrative burden on home care providers by requiring multiple payment systems for home care -- one for post-hospital patients and one for patients entering home care from the community -- and would require home care agencies to bill any number of hospitals for the care they provide to post-hospital patients rather than using the current single-billing system. This two-track system would result in uneven Medicare coverage for patients with the same care needs as hospitals interpret coverage rules differently.

Conclusion

Thank you again, Mr. Chairman, for the opportunity to present our views on this important topic. Home care has waited for many years to get to this point in the development and consideration of a prospective payment system for home care. You and the Committee have our thanks for bringing the issue to this level of consideration and we look forward to working closely with you in bringing PPS to enactment.

Chairman THOMAS. We all join in trying to get CBO to offer realistic assumptions.

Mr. Hoffman.

STATEMENT OF PHILLIP I. HOFFMAN, CHIEF FINANCIAL OFFICER, OUTREACH HEALTH SERVICES, AUSTIN, TEXAS, ON BEHALF OF THE PPS WORK GROUP

Mr. HOFFMAN. Mr. Chairman, my name is Phillip Hoffman. I am the chief financial officer of Outreach Health Services which provides Medicare covered home health services throughout the State of Texas for both for-profit and nonprofit organizations. We're only 25 years old.

I am testifying today on behalf of my company and the Prospective Payment System Work Group, a coalition of 20 State and national home health associations. My work experience includes participation in both phase I and phase II of the prospective payment demonstration project administered by the Health Care Financing Administration.

I have also participated in the Prospective Payment System Work Group which together with the National Association of Home Care has crafted the Revised Unified Prospective Payment Plan, which I will briefly describe today, as a substitute for the current cost reimbursement system and as an alternative to copayments. Several elements of this plan are modeled after the phase II demonstration project.

My grandmother, a first-generation American who came of age during the Great Depression, would have made an excellent policy advisor to you on how to run the Medicare home health program. Coping with the scarcities of this era taught her the value of a dollar. Accordingly, she would have cautioned against perpetuating cost-based reimbursement for the Medicare home health program.

Cost reimbursement creates an artificial marketplace governed by reimbursement regulations rather than market forces. The laws of supply and demand do not operate effectively in this environment because competition exists only for the quantity and quality of services. The concept of value is, for all intents and purposes, absent from consideration.

As a result, the Medicare home health care program has forgotten the value of a dollar. With the costs of providing services considered to be of only secondary importance, we should not be surprised that efficiency may be relegated to low-priority status by providers, unless their costs exceed the cost limits.

In fact, the cost reimbursement mechanism can actually create perverse incentives. When a home health agency's costs exceed the cost limits, it has an incentive to seek additional volume to average down its costs until they fall below the limit. However, when these efforts succeed to the point where the agency's costs are well below the limit, it loses any incentive to control its costs. Inevitably, costs creep up and the cycle begins again.

There is broad-based consensus in the home health community that high-quality services can be provided in a more cost-effective manner through a prospective payment system which rewards efficiency and creates disincentives for waste and inefficiency.

The Revised Unified Prospective Payment Plan achieves these objectives while creating significant savings for the Medicare Program. The plan's specifications draw upon three primary sources. First, the phase II home health prospective payment demonstration project approved by Health Care Financing Administration. Second, the home health prospective payment system passed by Congress during its last session. And third, the administration's home health payment reform proposal.

The plan structure includes the following principal components. First, per-visit payments will be maintained to preserve continuity with current practices and to preserve cash flow for providers. Per-visit payments would, however, be prospectively set based upon average costs in the provider's region during a base period.

Second, annual aggregate limits on payments to home health agencies would be imposed on both per-patient and per-episode bases.

Finally, savings sharing between the home health agency and the trust fund of the difference between total payments to the provider and the aggregate payment limits creates an incentive to control both utilization and cost.

The Revised Unified Plan structure calls for a phase-in of its various components. The phase-in approach was adopted to simplify implementation and address the Health Care Financing Administration's implementation concerns.

Phase I is in place for the first 24 months and includes the imposition of the annual per-patient payment limits to providers covering the full spectrum of covered home health services. This feature is similar to the administration's plan and was added to allay the Health Care Financing Administration's concerns regarding the difficulty in gathering data to implement per-episode payment limits.

In phase II, patient episode payment limits are introduced using the phase II demonstration project 120-day definition of an episode. A case mix adjuster, also borrowed from the phase II demonstration project, is employed to adjust the per-episode payment limits for expected differences in care requirements for different patient episodes.

Care delivered to patients beyond the 120-day episode is subject to an annual per-patient limit. In all cases, the savings sharing provision creates the incentive for home health agencies to provide cost-effective, efficient care. Within 4 years of implementation of the prospective payment system the Secretary will be required to present to Congress a pure per episode prospective payment system to be jointly developed by the Health Care Financing Administration, the industry, and consumers.

The case mix adjuster proposed for use in the Revised Unified Prospective Payment Plan has been criticized for its imprecision because it predicts only 9.7 percent of the variation in resource utilization between episodic categories. However, the hospital DRG system, which serves as the case mix adjuster for payments by the Medicare Program to hospitals and is considered by HCFA to be highly effective, predicts only approximately 35 percent of the variation in resource utilization between case-mix categories.

The primary purpose for the proposed case mix adjuster is to discourage attempts by providers to manipulate the system by chang-

ing their case mix in favor of short stay, low utilization patients. We believe that this case mix adjuster, even with its limitations, is adequate for that task.

To summarize, it is time for the government to become a more cost-conscious buyer of home health services. We need a system that encourages providers to be innovative in creating cost-effective approaches to quality care. The industry is ready. It has developed a realistic plan to accomplish this end and we believe that its implementation will achieve scorable savings comparable to those of the administration's plan over 6 years. But to move forward, we need your help.

I appreciate the opportunity to speak with you today and all three of us would be happy to entertain any of your questions.

[The prepared statement follows:]

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

HEARING BEFORE THE UNITED STATES COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

1100 Longworth Office Building
Tuesday, July 23, 1996

Medicare Payment Delivery for Home Health Agency and Skilled Nursing Facility Services

TESTIMONY OF PHILLIP I. HOFFMAN, M.B.A.

Mr. Chairman, my name is Phillip I. Hoffman. I am the Chief Financial Officer of Outreach Health Services, which provides Medicare covered home health services throughout the State of Texas through both for-profit and nonprofit organizations. I am testifying today on behalf of my company and the PPS Work Group, a coalition of twenty (20) state and national home health associations.

My work experiences includes participation in both Phase I and Phase II of the Prospective Payment Demonstration Project administered by the Health Care Financing Administration. I have also participated in the PPS Work Group which, together with the National Association for Home Care, has crafted the Revised Unified Prospective Payment Plan, which I will briefly describe today, as a substitute for the current cost reimbursement system and as an alternative to copayments. Several elements of this plan are modeled after the Phase II Demonstration project.

My grandmother, a first generation American who came of age during the Great Depression, would have made an excellent policy advisor to you on how to run the Medicare home health program. Coping with the scarcities of this era taught her the value of a dollar. Accordingly, she would have cautioned against the perpetuation of cost-based reimbursement in the Medicare home health program.

Cost reimbursement creates an artificial marketplace governed by reimbursement regulations rather than market forces. The laws of supply and demand do not operate in this environment because competition exists only for the quantity and quality of services. The concept of value is, for all intents and purposes, absent form consideration. In other words, the Medicare home health program has forgotten the value of a dollar. With the cost of providing services considered to be of only secondary importance, we should not be surprised that efficiency may be relegated to low priority status by home health agencies unless their costs exceed the cost limits.

In fact, the cost reimbursement mechanism can actually create perverse incentives. When a home health agency's costs exceed the cost limits, it has an incentive to seek additional volume to "average down" its costs until they are below the limit. However, when these efforts succeed to the point where the agency's costs are well below the limit, it has no incentive to control costs. Inevitably, cost creep up and the cycle begins again.

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The Revised Unified Prospective Payment Plan achieves these objectives while creating significant savings for the Medicare program. The plan's specifications draw upon three (3) primary sources:

1. the Phase II Home Health Prospective Payment Demonstration Project approved by HCFA;

2. the home health prospective payment system passed by Congress during its last session; and

3. the Administration's home health payment reform proposal.

The plan's structure includes the following principal components.

1. **Per visit payments** will be maintained to preserve continuity with current practices and to preserve cash flow for home health agencies. Per visit payments would, however, be prospectively set based upon average costs in the provider's region during a base period.

2. **Annual aggregate limits on payments** to home health agencies would be imposed on both per patient and per episode bases.

3. **Savings sharing** between the home health agency and the Trust Fund of the difference between total payments to providers and the aggregate payment limits creates an incentive to reduce both utilization and cost.

The Revised Unified Plan's structure calls for a phase in of its various components and simplification of Phase I. This approach was adopted to address HCFA's implementation concerns. Phase I is in place for the first 24 months and includes the imposition of annual per patient payment limits to providers covering the full spectrum of covered home health services. This feature is similar to the Administration's plan and was added to allay HCFA's concerns regarding the difficulty in gathering data to implement per episode payment limits.

In Phase II, patient episode payment limits are introduced using the Phase II Demonstration Project 120-day definition of an episode. A case mix adjuster, also borrowed from the Phase II Demonstration Project, is employed to adjust the per episode payment limits for expected differences in care requirements for different patient episodes. Care delivered to patients beyond the 120-day episode is subject to an annual per patient limit. In all cases, the savings sharing provision creates the incentive for home health agencies to provide cost effective, efficient care needed by their patients.

Within four (4) years from implementation of the prospective payment system, the Secretary will be required to present to Congress a pure per episode prospective payment system which is to be jointly developed by HCFA, the industry, and consumers.

The case mix adjuster proposed for use in the Revised Unified Prospective Payment Plan has been criticized for its imprecision because it predicts only approximately 10% of the variation in resource utilization between episodic categories. However, the hospital DRG system, which serves as the case mix adjuster for payments by the Medicare program to hospitals and is considered by HCFA to be highly effective, predicts only approximately 35% of the variation in resource utilization between case mix categories. The primary purpose for the case mix adjuster is to

discourage attempts by providers to manipulate the system by changing its case mix in favor of short stay, low utilization patients. We believe that the case mix adjuster, even with its limitations, is adequate for that task.

To summarize, it is time for the government to become a more cost conscious buyer of home health services. We need a system that encourages providers to be innovative in creating cost effective approaches to quality care.

The industry is ready. It has developed a realistic plan to accomplish this end, and we believe that its implementation will achieve scorable savings comparable to those of the Administration's plan over seven (7) years. But to move forward, we need your help.

I appreciate the opportunity to speak with you today and would be glad to answer any questions.

Chairman THOMAS. Well, thank you very much and I want to complement the gentleman for getting 10 minutes of testimony in, in the 5-minute period.

It makes it even more astounding when the gentleman is from Texas. [Laughter.]

Just one question and it was touched on by several of you—in terms of your most recent unified proposal and what it looks like in terms of CBO's analysis in that it probably would not provide savings and, in fact, it may cost more.

We hope that we can create a working environment if that is the case because although I am very much in favor of a prospective payment system, I am not in favor of one that does not reduce the costs, since that's one of the concerns that we have. It might make it more rational and rationality is a goal in terms of the payment structure, but reduction is also something that we need to deal with.

I would invite any comments in terms of all of us agreeing that we want CBO to be as realistic as possible in its estimates and you need to know that since the President's proposal, there has been an enormous growth curve in the understanding of how the health system works, not just by the Members of Congress, but by those folks who try to do estimating in the Congressional Budget Office as well.

The difficulty comes when we go cutting edge and talk about making changes in which there's simply no model that's available then we will always wind up with disagreements on the question of utilization and other problems. So, we certainly complement you in your effort to continue moving in the direction of creating a prospective payment system but we will pledge to you, working together, to make sure that when folks analyze it, they analyze it as fairly as possible.

But this is going to be an ongoing learning experience for all of us.

Mr. HOFFMAN. We appreciate your help.

Chairman THOMAS. I do note that all of you have talked about your opposition to any kind of a, even a modest copay. Historically they had the deductible. Just give me, in as encapsulated a way as possible, what's wrong with a very modest amount which people will use as a very weak screening device for making choices in terms of what they would do?

Most people think it's rather salutary that folks put up a very modest amount. Is it the degree of money that would be involved on the part of the beneficiary, is it that it is an item that could be racheted up, or is it the very concept of requiring a beneficiary to make even a modest copay that is troublesome to you, folk?

Mr. HOLT. Well, I would—I think we are all going to probably want to comment on that—but let me just start off by saying that I think that——

Chairman THOMAS. It's not necessary, but if you want to.

Mr. HOLT. I can not stop them. I think the copay will cause patients to refuse needed services in home health care. I think it will have, even if—I picture a nurse in a home saying to the patient, when the nurse knows and the physician has signed off on this treatment that the patient needs at home and the nurse begins to

approach a patient about a copay, will have a chilling effect on the patient's willingness to accept needed care. And because of that, I think that typically the patient will deteriorate without such home care services and will land back into the hospital or the nursing home.

It's extraordinarily difficult to bill and collect copay for this type of service and it will escalate the cost of the service. It can probably be accurately characterized as a sick tax and one that has a particularly harsh effect on frail elderly.

Peg and Phil may want to join me.

Ms. CUSHMAN. I second the piece on the frail and sick elderly. As was commented earlier, only a small portion, 10 percent, of all Medicare beneficiaries actually use the home care benefit. They tend to be older, they tend to be sicker and they tend to have a higher percentage in the poverty area.

But in addition to that, I would like to second the notion of the expense of the copay and I am certainly not advocating a less than modest or a greater than modest copay, as you suggested. But if, in fact, it were a modest copay, the cost of billing, because we are currently in cost-based reimbursement—and we have per-unit billing which are fairly small amounts compared to a big hospital room day—every single one of those items has to be generated on a duplicated basis, you would then attempt to collect. If we do not collect, it's appropriately Medicare bad debt and goes back to the system.

As I noted in my written testimony, there originally was a copayment in the home care/Medicare and it was more onerous than it was beneficial.

Chairman THOMAS. Before we get a third statement, if Mr. Hoffman wants to make it, it is our understanding that when you look at the patient profile, that payments are made by Medicaid and Medigap for what would amount to about 89 percent of the population. So, if we're talking about out-of-pocket expense, which is the onerous requirement on the nurse to collect the money at the time she's hovering over the patient at home, purporting to deliver a particular service, we're talking 10 to 11 percent of the population, are we not? Or, do you disagree with that 89 percent figure?

Mr. HOFFMAN. I have heard that assertion made on numerous occasions, as well, but I can only——

Chairman THOMAS. I hasten that it came from the Democratic staff, so——[Laughter.]

Mr. HOFFMAN. I can only tell you what the world is like where I come from and 90 percent of our patients are not covered by Medicaid or Medigap for home health care services. And even if a large proportion were covered by Medicaid, the Medicaid coverage for home health in Texas is not terribly liberal.

I think I would like to follow up on what Peg and Steve said, as well, with regard to the copayment and elaborate on the sick tax notion. These are not preventive services that we're talking about here. The services that are received by home health care beneficiaries are because these people are ill and these are exactly not the kind of services that you want them to not receive. There is no copayment for hospital stays, there is a high deductible to be sure but that high deductible is absorbed within the first day of hospital

care. Since there is no copayment for hospitals, for the very same reasons, there should be no copay for home care.

Chairman THOMAS. Truth in packaging requires me to state that our staff agrees with their staff on the 11 percent. But obviously, this is a statistic and it's nationwide and just like we find someone who's fast-talking from Austin, maybe you've got a situation which is an anomaly as well.

I do want to thank all of you though in terms of your clear understanding of what the administration's proposal on the $55 billion shift is. It is no solution. And, in fact, it would create the appearance of having solved the problem and I think all of us are primarily interested in solving problems rather than doing what, in part, has been done in the past and that is, appearing to solve problems.

Now, does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

I just want to see if the panel can clear up my confusion on the suggested prospective payment plan. In the aggregate limits, would those be an aggregate limit per person or would they be an aggregate limit, depending on the diagnosis?

Mr. HOFFMAN. I am sorry, what was the second part of your question?

Mr. STARK. You have episode per-patient limits. Let's just stick with the patient limit, annual aggregate limit.

Mr. HOFFMAN. Right.

Mr. STARK. Would that be the same limit for a hip replacement as it would be for a stroke?

Mr. HOFFMAN. The answer is, yes, in phase I.

Mr. STARK. OK. That does not make sense to me. If you know that somebody normally only takes two or three visits on one diagnosis and 100 visits on the other, we are not saving any money.

Mr. HOFFMAN. Right. What you are suggesting is exactly what a case mix adjuster is designed to take account of. The problem that we have, as we have been told by the Health Care Financing Administration, is that it would take them some time to gather the data in order to implement the case mix adjuster and that is the purpose for phase I.

Mr. STARK. OK. So, that's only initially?

Mr. HOFFMAN. Exactly. And our industry goal would be for that phase I period to be as short as possible.

Mr. STARK. OK, and the per-payment visit would be established by the prospective, whatever, the DRG let's call it for lack of a better word.

Mr. HOFFMAN. The episodic limit?

Mr. STARK. Yes.

Mr. HOFFMAN. Yes.

Mr. STARK. And the per——

Mr. HOFFMAN. The per-visit payments would be established based upon the regional costs in the same fashion, that is, using the same methodology of cost limits.

Mr. STARK. The proprietary charges out when you calculate that, right?

Mr. HOFFMAN. I beg your pardon?

Mr. STARK. You leave the proprietary charges, which are much higher than nonprofit charges, out, calculated on a median charge?

Mr. HOFFMAN. All costs would be averaged in together.

Mr. STARK. Including the proprietaries?

Mr. HOFFMAN. Yes, sir.

Mr. STARK. Oh, come on. How about just the not-for-profit and the municipals?

Mr. HOFFMAN. Well, I think, as a matter of fact, at least for the per-visit costs, the proprietary, the data suggests that the proprietary costs per visit is lower than the not-for-profit and hospital-based costs per visit.

Mr. STARK. I am not sure that's the data I have been seeing, but if that's true then you should agree with me that we should keep them out.

Mr. HOLT. If I may——

Mr. STARK. Yes. Let me just go back on the copayment. While I have never been a great advocate of copays other than minimal, and by minimal, I am talking $5 or $10, whether that is a day or whatever, in capitated HMOs that provide pharmaceutical charges or visits, one has found that there is some minimal amount that seems to discourage overutilization by the patient and, yet, not discourage people from getting needed care. That's hard to find where that is, but let's say, it's $5 or let's say it is $10.

And, there are only 10 or 11 percent of the Medicare beneficiaries that are not either covered by Medicaid or Medigap. So, you're talking about a very small number whose copayment would not be picked up by insurance. And that, my colleagues and I have not had any complaints, that we know of, on the copay for hospitals which is now, since I have been in this racket, up to $730. That would provide 6 or 8 months of copays for home health visits, if you figure every third day at $100 a visit and a $10 copay.

Other than maybe a dislike, a philosophic dislike, which I am not sure is wrong, there might just be some incentive for the patient to save, too, and say, "no, do not come back next Thursday, I think I can make it without you coming back." And, the theory that my mother would not figure out that she is not saving $10 for Prudential, she's saving it, in general.

What's such a big deal about that?

Mr. HOFFMAN. I think that—and I am not as familiar with the data as I probably should be—but I believe that if 90 percent is the number then I would imagine that the vast majority of that 90 percent is Medicaid as opposed to Medigap and I think that Medicaid probably does a much better job of covering the hospital deductible——

Mr. STARK. No, no, no.

I mean Medicaid covers, I am going to guess, one-third of the Medicare beneficiaries and I am going to guess that the biggest balance of 50 or 60 percent on top of that have Medigap insurance. This is widely held. They would pay, most policies would pay some kind of copay.

Mr. HOFFMAN. Again, I cannot comment on that nationally. I know for the patients that we serve, the majority of our patients do not have that Medigap insurance.

Mr. STARK. They have it, but it may not cover you.

Mr. HOFFMAN. That could very well be, yes, sir.

Ms. CUSHMAN. If I could, on the theory that 90 percent does not pay out-of-pocket——

Mr. STARK. Or 85 or whatever, But yes.

Ms. CUSHMAN [continuing]. Then that also is not an out-of-pocket discouraging factor for the beneficiary. So, for that 90 percent, that also would not achieve what I think I am hearing you say we would like to.

In the instance of a prescription drug copay ordinarily the individual is there at the pharmacy and hands the money over. It's not a separate billing. For the modest amount, again, the billing and the added personnel required to literally double-bill and attempt to collect every single unit of service would be extremely expensive.

Mr. STARK. That makes sense.

Mr. Holt, I cut you off but if the chair wants to let you respond, go ahead. I am sorry.

Mr. HOLT. Thank you. One last thing on the copay, I have just been in too many patients homes where the mere mention of it is a chilling effect on the patient's self-denial of care that they need. That would ultimately cost more dollars because the patient will deteriorate in their home and go back into the hospital.

On what I was going to say earlier relating to utilizing a variety of auspices, for-profit, not-for-profit, hospitals to determine these, I, too, had some concerns about that from a nonprofit perspective, since, I am from a nonprofit agency. But, in order to get the industry support, which was necessary, we all had to make compromises along the way. That was one that we made so we could get the industry support needed to carry this to the Hill.

Mr. STARK. And you made a little extra in the bargain.

Thank you.

Mrs. JOHNSON [presiding]. The chairman is temporarily gone but he indicated I should go ahead.

I want to give you this chance to really talk about your unified proposal and particularly to talk about how, in phase I, your proposal would both reduce costs and assure quality of services. And, how you would respond to CBO's claim that there would be so much gaming of the system that they should discount your estimates of savings by two-thirds.

Let's just look at that first phase of the 2 years. I think once we get a case mix adjuster in there, I think it's not going to be so hard to agree on an episode payment. But what we do in the interim is extremely important.

Mr. HOFFMAN. Well, the way the plan saves money in phase I, it saves money really in two ways. On the one hand, by virtue of having the per-patient limit, the maximum amount that Medicare would pay for services on a per-patient basis would be capped, it would be frozen at historical utilization levels.

The second way that the program would save money would be by providing the incentive for providers to actually provide more efficient care because there is a savings sharing provision in the plan.

So, that if——

Mrs. JOHNSON. Excuse me, how does that work?

Mr. HOFFMAN. I am just going to describe that. If I could use a hypothetical example, if the patient cap, the aggregate annual pa-

tient cap for an agency was $1 million but the agency's total per visit payments were $700,000 during a year, that would constitute a savings to the program of $300,000 which the program would split with the provider on a 50/50 basis subject to the provider's profits being limited to 10 percent of the total payments that they receive in a year.

So, the provider would have a very clear incentive to provide efficient care and would have no incentive, whatsoever, to overutilize services. It would work against them to do that.

Mrs. JOHNSON. But if they go over their cap, as a result of the demand——

Mr. HOFFMAN. Then those excess payments would have to be repaid to the program, dollar for dollar.

Mrs. JOHNSON. Where is the disincentive to not care for more patients than you can get reimbursed for? That procedure cap.

Mr. HOFFMAN. Now, we're talking about a problem at the other end of the spectrum and that's where the importance of monitoring comes. As part of our proposal we propose a peer review approach to help control quality.

Mrs. JOHNSON. I can see that peer review might be able to control volume, but would it be possible for an agency to simply charge the maximum and, in a sense, multiply the services for a smaller caseload, and get up to their cap, that's all they can earn. And, say, we've spent all this money, and we are not going to do any more?

Mr. HOFFMAN. During phase I, there is a theoretical potential for the type of gaming that you suggest because the absence of the case mix adjuster, which is why we advocate that that period be for as short a period of time as possible.

However, I can tell you that out there in the home health world, I know my agency and I would think most other agencies would find it to be quite foolish to change one's case mix intentionally to go and seek out those short-stay, low-utilization patients in return for a short-lived gain.

Mrs. JOHNSON. And, the cap during this initial period is based on the average cost of patients for that agency?

Mr. HOFFMAN. During phase I, during the first 12 months, the cap is 75-percent agency specific and 25-percent census region. It's a weighted average. And then, during the second 12 months that weight changes to 50-percent agency specific and 50-percent census region.

Mrs. JOHNSON. Thank you.

Anyone else want to contribute to how that first part works?

Mr. HOLT. Well, I think I agree with Phil that it's theoretically possible in phase I, not practically though, from the home agency standpoint to shift operations for only one year. It's difficult enough just to make a billing change in an agency.

But then also, although certainly even given that, the phase I is vastly superior to what we have now in terms of managing growth, I would say. So, it's not perfect and none of us will say it's perfect but we would go for the good rather than searching for the illusory perfect.

Mrs. JOHNSON. And so, how would you answer the Congressional Budget Office's gaming charges?

Ms. CUSHMAN. I'd like to make one comment in that my understanding is that one of the major issues that Congressional Budget Office is claiming is that agencies could increase the number of beneficiaries receiving home care. That's also possible under the current methodology. I actually fail to understand how agencies could increase the pool of individuals who would want to receive home care while, since those who are in need welcome someone in their home to assist them, most individuals, if they really do not have a need for care and services do not want someone unnecessarily into their home doing things.

There's also the safeguards of medical necessity and all the coverage requirements of the current Medicare law for home care.

Mr. HOFFMAN. I would echo that. There are no meaningful incentives introduced by prospective payment system to scrounge up patients than exist under current law and reimbursement.

Mrs. JOHNSON. Aren't there also criteria in the Medigap policies, that is billing criteria for home care?

Mr. HOFFMAN. I do not know.

Mr. STARK. Would the gentlelady yield?

Mrs. JOHNSON. I would be happy to yield.

Mr. STARK. It seems to me there is an incentive though that you do not deal with in the hospital owned subacute facilities. You got a DRG, the hospital gets the payment. You come in for a hip transplant and that averages 3 days. So, we have set the DRG based on the fact that you're going to be in the hospital for 3 days.

The hospital says to you, you got your hip, we got good subacute care, you go home or you go to our SNF. They boot you out a day or two early into their hospital owned subacute facility or home care facility and then they double dip. They get the full DRG and then they get the payment from the home health or SNF which all goes into the same pot. Basically they get a larger payment when they probably should have kept the patient in there the full 3 days anyway.

Now, how do you deal with that under your plan—where you got this all in one ball of wax, the ownership of the facilities, the home health agency or the subacute agency and the acute care hospital?

Ms. CUSHMAN. If I could——

Mr. STARK. I am saying the hospital ought to keep them longer. We've been spending all our time trying to get the hospital to get them out faster. Now, we say, wait a minute, if you do that, maybe we ought to cut your DRG payments. But that gets——

Ms. CUSHMAN. If I understand the question, it is how does prospective payment in home care address or how does it articulate the hospital's, I gather, appropriately discharging patients earlier, into another setting where they can be treated effectively.

Mr. STARK. Well, there's an incentive for them because they end up getting more money. They save a day or so. There's an incentive to cut short the acute care stay and that's a matter of judgment, it's a close call. But there's a financial incentive now to get them into their hospital owned facility, to get a second reimbursement, if you will, for that third day.

Let's say everybody agrees it's a 3-day stay but if you can get them out at the end of the second day, they get paid in the DRG

for the third day and they also get paid for it in the home health care or acute or SNF care.

Mr. HOFFMAN. I am sure that's true but——

Mrs. JOHNSON. If I could interrupt for a minute.

In a sense every hospital has an incentive because if they get someone out earlier they make more money in the DRG. What I think the gentleman from California is trying to say is that if they also are the ones who receive the payment for the home health care, while they have to provide that service they do get more money because they get both payments. They also have to provide both sets of services.

Mr. HOFFMAN. Right. I have never thought about it that way but I would agree with your analysis. I would think, nevertheless, that it should be the goal of the program to get the earliest possible appropriate discharge of patients out of the hospital.

Mr. STARK. If the gentlelady would yield. There was some data and I have it here in this mess of papers, that shows far higher utilization of home health care agencies from hospitals who owned the facility. I mean significantly higher utilization of SNFs and/or home health care where the discharging hospital owned that facility and I am going to say by a factor of two times.

Mrs. JOHNSON. See, the problem in my estimation is that we really do not have the information and this is what I was trying to bring up with ProPAC as to whether that is a better continuum of care, from the patient's point of view. Was it better to get out a day early with an appropriate home care or not?

So, it may be that where the hospital owns both of these facilities they are more conscious and where they do not, they are not as informed about what home care can do.

Anyway, your comments?

Mr. HOLT. Well, if I may, and then the question was, how does this prospective payment system impact such a situation? It may very well be if you go back to the nature of the prospective payment system is that the incentive is not just to provide more visits. The incentive is to clinically manage the care within your aggregate cap.

Now, they would still have the incentive to discharge to their own home health agency, that has not changed.

Mr. STARK. We're getting dangerously close to a word you do not like which is bundling. So, we'll move away from that, because the minute you begin to—I mean that, you begin to say well, maybe somebody ought to look at this continuum of care and make a decision. Dollars ought not to impact on that.

Ms. CUSHMAN. I would like to add that while it is true that there are many other issues surrounding the prospective payment for home care, we still feel this is an enormous step in the right direction. And the creation of an episodic system would push us in the direction of both gathering the data and designing the episode related to home care which would make it easier to rearticulate that back to the care in other settings in a bigger policy framework at a later date.

Mr. STARK. I agree.

Mr. HOFFMAN. And, I would echo that sentiment as well. If we wait until we know everything before we do anything, we will never do anything.

Mrs. JOHNSON. I think the real strength of your proposal is that it gives us a reasonable place to start and it gives us the incentive to get the work done to move forward.

I thank you for your testimony and yield back to the chairman.

Chairman THOMAS [presiding]. Thank you very much.

Does someone from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

Most of the questions I had have been asked. I want some clarification though on the annual aggregate cap. Is that per home health agency?

Mr. HOFFMAN. Yes. In phase I that is home health agency specific because there is a agency specific component to that being 75 percent in the first 12 months and 50 percent in the second 12 months

Mr. MCCRERY. And, explain to me how that cap is derived?

Mr. HOFFMAN. Well, the portion of it that is not agency-specific is based upon the average cost per patient, the average historical cost per patient in the base year in the census region. For the agency-specific component it is based upon that specific agency's historical cost per patient in the base year, if I said that correctly.

Mr. MCCRERY. Yes. But is there some estimate made of the number of patients to be served in that year or is it actual patients served——

Mr. HOFFMAN. No. It's actual patients served in the base year. It's actual cost and actual patients. There's no projection, whatsoever.

Mr. MCCRERY. OK, thank you.

Mr. HOFFMAN. I take that back. There is a projection but it is with regard to the inflation update only but there is no agency-specific projection, whatsoever.

Mr. STARK. Mr. Chairman, I was distracted a moment when you asked the question, Jim. Did you ask and did you say that the aggregate limit is for the home health agency?

Mr. HOFFMAN. In phase I the limit is applied on an annual basis to each home health agency.

Mr. STARK. For their gross income or for their per-patient charge?

Mr. HOFFMAN. The annual aggregate amount of the caps, which is the per-patient cap multiplied by the number of patients that they served during that year, that number is compared with the actual payments that are received by the home health agency. So, the cap is not applied on a per-patient basis, it is applied in the aggregate, but for each agency.

Ms. CUSHMAN. This is a great deal like the hospice per diem aggregated cap in how it's applied where you compare, as Phil was saying, the number of patients served. If some are over and others are under that average annual limit, it can average out for an agency. They must stay within that aggregated annual cap.

Mr. HOFFMAN. Correct.

Mr. MCCRERY. But in phase I, you continue to be paid under the current——

Mr. HOFFMAN. Per visit basis but it is no longer a cost reimbursement. It is no longer a cost reimbursed visit. It is a prospectively set rate based upon the average cost in the base year in your region for nursing visits or home health aid visits

Mr. MCCRERY. OK. And so, what you're saying is because of the aggregate limit, you have an incentive not to take more patients and not to create more visits per patient.

Mr. HOFFMAN. Well, the aggregate limit is for the benefit of the program in that it ensures that the program will not spend more than *x* dollars per patient per year.

Mr. MCCRERY. Yes, so, it's not a disincentive to not add more patients. It is a disincentive not to add more visits per patient?

Mr. HOFFMAN. That's correct.

Ms. CUSHMAN. And, there is also an incentive under the regionally set visit payment, which would encourage agencies to bring any cost per visit that they have in line with their regional average or less

Mr. MCCRERY. OK. So, you have not really addressed Dr. Johnson's concern that as we go to a prospective payment system, home health agencies will have the incentive to simply add more patients.

Can you address that?

Mr. HOFFMAN. This proposal does not limit access to the system. We reject the notion that there will be a groundswell of additional patients admitted into home care because I think we're serving as many patients as we can right now.

But we reject the notion that there will be that wood-work theory, if you will, but if there is—and we do not think that there is—this proposal does not address that issue.

Mr. HOLT. And the largest portion of the growth has come from utilization per patient. That's been the largest reason for the growth in home care utilization per patient. So, I think that's a key factor in managing this growth through a prospective payment system.

I agree with Peg. Most patients do not want, unless they really need, people coming into their homes. I mean that's just from the trenches, they really do not want clinicians there unless they need them.

I prefer using the words clinically managed, in oppose to, the prospective payment system. Because the physician and the nurse will be saying, within this aggregate cap, I have to be challenged to meet certain patient outcomes within the amount of money I have. The whole headset of the physician and the nurse clinician in the home changes because they say, given this cap, I must achieve certain outcomes.

The whole thinking is, I have this much money and I have to do this with this much money and I have to do this with this kind of resource. That is a way of thinking in terms of unlimited visits that does not exist presently.

Mr. STARK. Mr. Holt, I bet you a nickel that you would not find more than one in 100 doctors that currently signs off on home health care treatment that has the foggiest idea of what it costs or how many visits there will be. They just look at that thing and sign off.

Mr. HOLT. Well, I suspect there is a lot of physician education we still need to be doing.

Mr. STARK. And they are going to resist being held responsible for it. I mean now if you took it out of their pay they might get real responsible real quick, but I do not think we can look to them to have, you know, to control your part of the treatment plans.

Mr. HOLT. Well, this prospective payment system puts it on the back of the provider. You know, it is a provider-based prospective payment system.

Ms. CUSHMAN. Mr. Stark, I would like to say I do see that changing and while I do not see it happening overnight, I expect that within a reasonable period of time you will see far more physicians, far more interested and knowledgeable about what home health care can and should do.

Mr. STARK. But, don't you think that will come with more capitated systems, and more of the staff model HMO type systems where they do own the hospital and the home health service, but they're getting a capitated rate.

Ms. CUSHMAN. It's coming partly from capitation and it's also coming from where physician education had nothing to do with home health care just a few short years ago, and now, something like 8 out of 10 medical schools require information and rotation into home care and community settings.

Mr. HOLT. I think there's a very practical reason. Patients are going to be cared for in the home ultimately anyway. That's where the patients are going to be so the physicians will have to be familiar with it.

Mr. STARK. Thank you.

Chairman THOMAS. The gentleman from Louisiana's time has expired.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Just briefly, Mr. Chairman.

Mr. Holt, you made a comment concerning the copayment that it might have a chilling effect on needed care. You are partially correct. I think it could have a chilling effect but I think it would have a chilling effect on some of the care that may not be needed and bring down the costs there.

So, I guess I would encourage you to look at not taking a hardline position on that issue and seeing if that might be something we could look at.

I also wanted to ask Ms. Cushman if you had any data that showed that the length of stay at hospitals had been significantly reduced or reduced at all by the use of home health care services or if your organization had any of that data at their access?

Ms. CUSHMAN. The National Association for Home Care can provide that information for you subsequent to this hearing. Anecdotally I can share with you as a single agency, we have both been able to get patients out of hospitals earlier and, equally significantly, avoid some hospitalizations that previously would have been necessary that is both made possible now by increased technology that can be used at home and increased sophistications of skills of practitioners.

Mr. CHRISTENSEN. Over the last 5 years your payment per visit has grown 3 percent. During that time, have you had many ancil-

lary type of procedures performed on home health care or has it been pretty much stationary?

Ms. CUSHMAN. Could you explain what you mean by ancillary?

Mr. CHRISTENSEN. Has your procedure changed over the last 5 years in terms of services provided? At the payment per visit rising at 3 percent, I commend you in that area, have your needs for services expanded throughout those 5 years?

Ms. CUSHMAN. What's really quite remarkable is you are saying 3 percent. I have also seen 2 percent on average. That the average increase in the cost per unit is so low when the complexity that we are seeing, the technology that we are using—which is always more expensive—and all of the other things that are required of us, including increased training requirements that have been passed federally for home health aids, the increases in expense due to OSHA requirements and CLIA regulations and everything else to be very, very high, we have actually been able to almost reverse that growth trend in visit costs.

Mr. CHRISTENSEN. I would say good job and I would like to see some of the recommendations from your organization on areas that we can help in terms of OSHA, deregulation in areas that you think that we could improve and help the small business owner in making their job easier, and continue to provide the type of service that we need and protections for the patient. Also, we know that the Federal Government has its hand in too many areas. And oftentimes, it thinks it has the cure for everything. If we can help somewhere, we would be open to find out where you think OSHA has overstepped their boundary.

Ms. CUSHMAN. We will be happy to provide you with that information.

[The following was subsequently received:]

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HOME HEALTH AGENCIES AND HOSPICES SHOULD BE EXEMPT FROM CLINICAL LABS IMPROVEMENTS ACT

CLIA was intended to regulate laboratories in order to increase the safety and quality of laboratory tests performed in the U.S. Unfortunately, this law was written so broadly that it imposed new paperwork and fee requirements on thousands of home health agencies and hospices that perform only simple tests -- tests that are available to any home user over the counter from any drug store.

Nearly 90 percent of all Medicare certified home health agencies and hospices perform simple and routine tests that the FDA agrees pose no health or safety risk to patients. Under CLIA, agencies that perform only these tests must apply every two years to HCFA for a waiver from CLIA requirements. This application includes completion of a four page form plus payment of a $100 fee.

Only about 20 percent of Medicare certified home care agencies and hospices perform tests that are complex and that CLIA was intended to regulate.

Proposal: CLIA should be amended to require that only home health agencies and hospices that perform complex tests must apply to HCFA for certification. Agencies and hospices that do not apply for certification should be assumed to be performing no tests beyond those tests approved by the FDA as simple and routine. The current survey and certification process under which all Medicare certified home care agencies and hospices must prove their compliance with HCFA regulations and requirements would serve as a check on whether agencies who have not applied for and received CLIA certification are performing complex tests.

INFLUENCE OSHA REGULATIONS AND ENFORCEMENT AS APPROPRIATE TO THE HOME CARE AND HOSPICE SETTING

ISSUE: Under OSHA's general duty clause, employers are mandated to ensure the safety of their employees in the work setting. OSHA has several proposed regulations that would affect home care agencies and hospices, including driver safety and ergonomics in the workplace. Also, OSHA is currently enforcing regulations which affect all health care workers who are at risk for exposure to bloodborne pathogens and tuberculosis.

While these rules apply to all home care and hospice employers and subsequently their employees, there are certain workers who contract directly with states (independent providers) who are exempt from the rules, but provide in-home services. These states have evaded their responsibility for public health and safety by determining these contract workers to be employees of the client rather than the state, thereby denying the worker and the client protection from potential harm.

RECOMMENDATION:

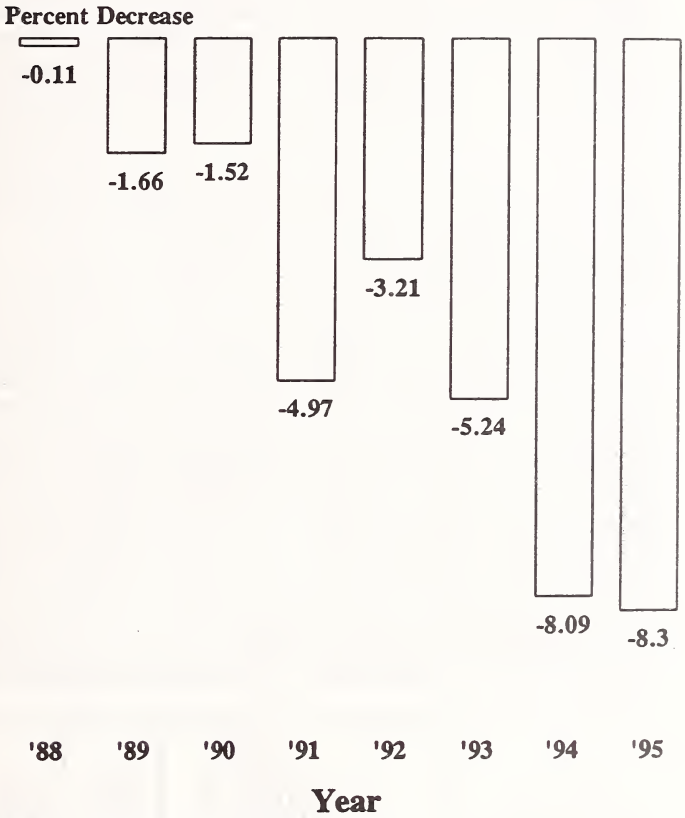
1. OSHA regulations that are applied to the home care and hospice industry should meet the following criteria:

- o There is a demonstrated significant employee safety problem in the home care industry;
- o The proposed remedy is feasible and cost-effective in the home setting;
- o OSHA rules do not duplicate other requirements;
- o Voluntary guidelines have been implemented and did not produce the needed changes; and
- o Home care employers are not held responsible for offsite compliance by the employee.

2. Important client-worker protections should be extended to all home care workers, regardless of who is considered to be the employer. States should be required to ensure that personal care workers who provide services which are financed under federal programs and who run the risk of occupational exposure to hazards are protected.

RATIONALE: All home care workers should be afforded appropriate health and safety protection. Hospice and home care employees are at risk for injuries secondary to auto accidents and musculoskeletal injuries. The potential for exposure to tuberculosis is ever present when providing services in the community. It is incumbent upon NAHC to assist home care agencies and hospices in the application of regulations and guidelines. However, it is critical that OSHA and enforcement inspectors recognize the limitations of imposing restrictions and equipment requirements in a patient's home. Furthermore, employers should not be penalized for employees' failure to conform to safety regulations when outside of the employer's control.

Shortening LOS for Subacute-Related DRGs



Contact: Gary F. Capistrant, Vice-President
Health & Senior Living
U.S. Strategies Corp.
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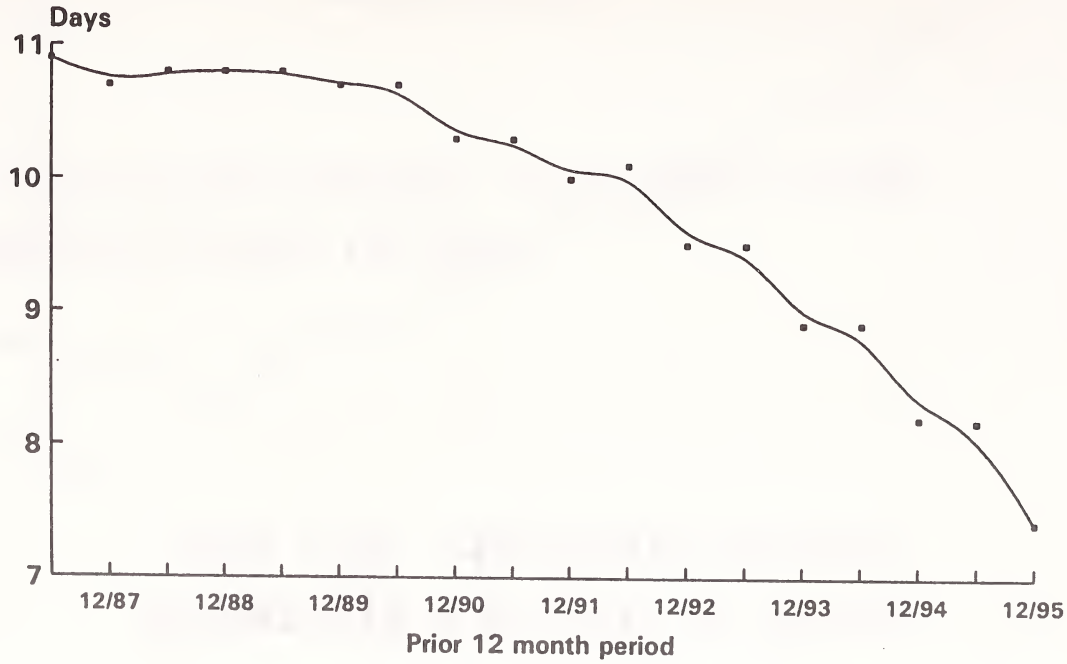
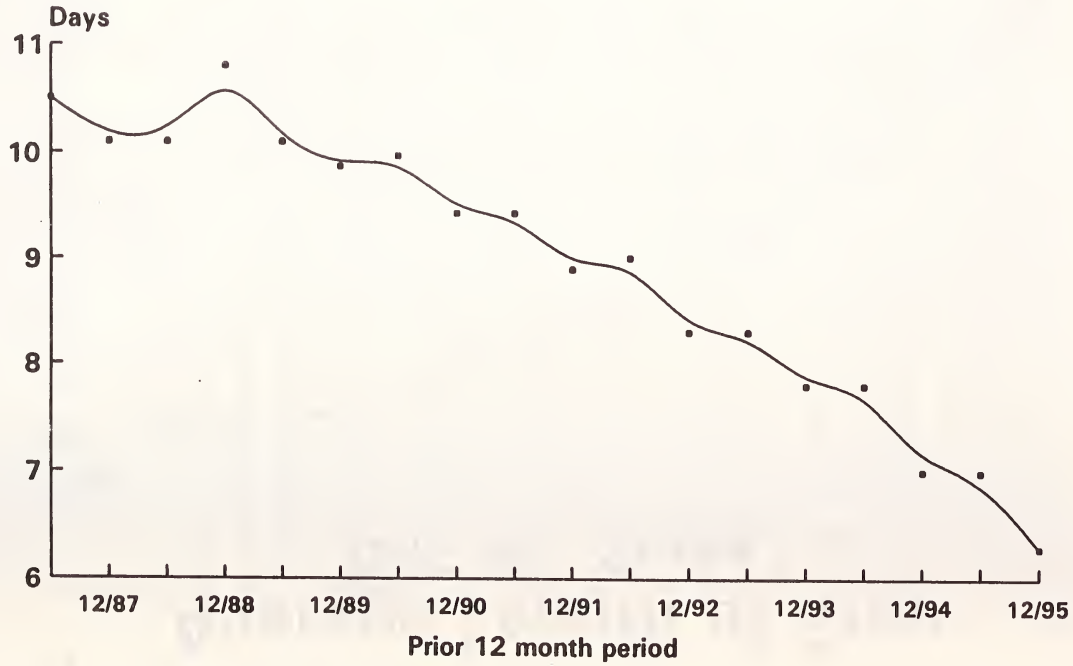
DRG	Average length of stay Description	%	lscharges 8/87	lscharges 12/95	FY88 8/87	P89 2/87	FY89 8/88	P90 3/88	FY90 8/89	P91 2/89	FY91 8/90	P92 2/90	FY92 8/91	P93 2/91	FY93 8/92	P94 2/92	FY94 8/93	P95 2/93	FY95 8/94	P96 2/94	FY96 8/95	P97 2/96	ANNUAL PERCENTAGE CHANGE 88	89	90	91	92	93	94	95
1	Craniotomy age > 17 except for trauma	50	23400	32723	10.1	10.0	10.2	10.3	10.5	10.0	10.1	17.1	17.3	15.7	10.0	14.7	14.0	13.5	13.0	12.4	12.4	11.0	1.00	-2.00	-7.00	-0.13	-0.44	-0.01	-0.40	-10.00
12	Degenerative nervous system disorders	80	31000	23255	10.7	10.5	10.7	10.0	11.0	10.0	10.0	10.5	10.0	10.4	10.7	10.1	10.1	0.3	0.3	0.0	0.7	7.0	2.02	-0.22	-1.70	-1.71	-3.30	-7.00	-7.40	-11.77
14	Specific cerebrovascular disorders except TIA	50	310604	301205	10.0	10.7	10.0	10.0	10.0	10.7	10.7	10.3	10.3	10.0	10.1	0.0	0.5	0.0	0.0	0.2	0.2	7.4	0.00	-1.22	-3.10	-3.44	-4.40	-0.20	-0.40	-0.27
75	Major chest procedures	50	20420	30401	15.0	15.2	10.3	14.0	14.7	14.3	14.4	14.1	14.1	13.7	13.0	13.1	13.1	12.0	12.7	11.0	11.0	11.1	-3.07	-1.03	-1.27	-3.12	-4.31	-3.00	-0.00	-0.20
76	Other respiratory system O.R. procedures w cc	50	12400	30705	17.0	13.3	13.4	14.0	10.0	14.0	14.0	14.0	14.0	14.3	14.0	14.0	14.0	14.1	14.2	13.3	13.4	12.0	12.44	-0.71	0.50	-2.04	1.03	-2.34	-5.70	-0.03
79	Respiratory infections & inflammations age > 17 w cc	80	93802	207908	12.7	13.0	13.1	12.5	12.3	12.4	12.5	12.2	12.3	11.0	11.0	11.4	11.4	10.0	10.0	10.1	10.1	0.2	-3.03	-0.04	-0.07	-0.34	-1.03	-0.10	-0.02	-7.00
85	Pleural effusion w cc	50	10203	10380	0.0	0.3	0.3	0.1	0.1	0.2	0.2	0.1	0.1	0.0	0.1	0.7	0.7	0.2	0.3	7.0	7.0	7.3	-1.01	0.00	-1.20	-1.00	-2.00	-0.07	-5.02	-5.03
88	Chronic obstructive pulmonary disease	80	183837	348305	0.2	0.1	0.2	7.0	7.0	7.7	7.7	7.5	7.5	7.3	7.4	7.3	7.3	7.0	7.0	0.0	0.0	0.1	-2.75	-3.22	-2.17	-2.07	-1.00	-3.50	0.10	-7.70
89	Simple pneumonia & pleurisy age > 17 w cc	50	340750	415072	0.0	0.5	0.0	0.2	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.5	0.5	0.1	0.1	7.0	7.0	7.1	-3.20	-0.00	-1.17	-3.00	-1.00	-4.40	-0.50	-0.01
90	Simple pneumonia & pleurisy age > 17 w/o cc	80	10720	40308	0.4	7.2	7.2	0.0	0.0	0.7	0.7	0.4	0.4	0.2	0.2	0.0	0.0	5.7	5.0	5.4	0.4	0.1	-0.00	-1.27	-3.07	-3.70	-2.40	-3.00	-0.10	-4.72
96	Bronchitis & asthma age > 17 w cc	80	200054	80807	7.2	7.5	7.0	7.3	7.4	7.3	7.3	7.2	7.3	7.1	7.1	0.7	0.7	0.3	0.3	5.0	0.0	0.0	-2.02	-1.01	-0.31	-2.02	-4.70	-0.70	-7.20	-0.20
104	Cardiac valve procedure w cardiac cath	50	X	22054	X	X	X	X	X	22.0	23.3	22.3	22.0	20.3	20.2	10.5	10.0	10.1	10.1	10.0	10.0	14.0			-1.70	-10.00	-3.05	-7.50	-11.26	-0.20
105	Cardiac valve procedure w/o cardiac cath	80	X	10021	X	X	X	X	X	10.0	17.1	10.2	10.3	14.4	14.0	14.0	14.0	13.3	12.2	12.0	12.0	10.0			-3.10	-11.30	-2.07	4.02	-10.06	-0.07
106	Coronary bypass w cardiac cath	50	42200	90100	10.0	10.0	10.0	10.0	17.0	10.3	10.4	10.0	10.7	15.2	10.2	14.7	14.7	12.0	13.0	12.7	12.7	11.7	1.03	-3.50	-3.74	-3.10	-2.20	-0.00	-0.20	-7.05
107	Coronary bypass w/o cardiac cath	50	34142	01750	13.1	13.1	13.2	12.0	13.0	12.5	12.0	13.0	13.0	11.0	11.0	11.2	11.2	10.0	10.0	0.0	0.0	0.0	-1.03	-3.11	11.00	-15.44	-4.57	-0.20	-0.20	-0.51
112	Amputation for circ system disorders except upper limb & t	80	20017	45003	10.0	10.1	10.3	10.0	10.2	10.2	10.4	10.3	10.4	10.0	10.0	10.4	10.0	17.4	17.0	15.0	10.0	14.2	0.22	-4.34	0.02	-2.30	-1.00	-0.02	0.70	-0.01
121	Circulatory disorders w AMI & c.v. comp disch alive	20	122170	100020	11.3	11.0	11.0	10.0	10.7	10.1	10.2	10.0	10.0	0.0	0.0	0.2	0.2	0.7	0.7	0.0	0.0	7.4	-2.75	4.07	1.34	-4.00	4.10	0.24	-7.02	-7.00
126	Acute & subacute endocarditis	80	2204	4010	22.0	22.4	22.5	22.1	22.3	22.1	22.1	31.0	21.0	20.4	20.4	10.2	10.4	10.2	10.3	15.0	10.0	14.0	-1.21	0.07	-0.00	-0.73	-5.20	-5.72	-12.13	-11.00
127	Heart failure & shock	50	500070	070401	0.1	0.2	0.2	0.1	0.1	0.0	0.0	7.0	7.0	7.7	7.7	7.0	7.5	7.2	7.2	0.7	0.7	0.2	-0.01	-1.20	-1.10	-2.40	-2.20	-4.54	-0.74	-7.40
128	Deep vein thrombophlebitis	80	30302	10012	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.4	0.1	0.1	7.7	7.7	7.2	7.2	0.7	-2.41	-2.10	-2.02	-1.00	-3.57	-0.00	-0.22	-0.70
130	Peripheral vascular disorders w cc	80	01254	01020	7.4	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	7.0	7.0	7.5	7.5	7.1	7.1	0.7	0.00	0.00	-0.10	-1.00	-3.50	-2.30	-0.40	-0.17
148	Major small & large bowel procedures w cc	50	124304	140141	10.0	17.5	17.7	17.0	17.7	17.2	17.3	10.7	10.7	10.0	10.0	10.0	10.5	14.0	10.0	14.1	14.1	12.4	0.40	-2.37	-2.00	-0.37	-2.24	-3.70	-0.00	-4.07
150	Peritoneal adhesiolysis w cc	50	10402	22610	14.1	15.3	10.4	10.2	10.3	14.0	14.0	14.0	14.1	13.0	13.0	12.4	12.4	12.0	12.0	12.3	12.2	11.7	-0.00	-4.04	-2.70	-1.21	-3.01	-3.00	-4.00	-4.73
154	Stomach, esophageal & duodenal procedures age > 17 w cc	80	44083	25001	10.0	17.0	17.7	17.0	17.0	17.1	17.2	10.0	10.0	17.0	10.1	17.7	17.0	17.2	17.2	10.0	10.0	10.0	-0.21	-2.02	10.42	-5.17	-1.03	-3.32	0.70	-0.50
170	Other digestive system O.R. procedures w cc	50	17808	12483	15.4	10.1	10.3	10.0	17.0	10.0	10.7	10.4	10.5	10.0	10.0	10.4	10.0	14.7	14.0	13.2	12.3	12.4	4.00	-1.20	-0.22	-0.20	-1.17	-4.00	-0.00	-0.20
172	Digestive malignancy w cc	80	30770	30020	0.0	10.0	10.5	10.0	10.0	10.7	10.7	10.4	10.4	10.3	10.0	10.1	10.1	0.5	0.5	0.7	0.7	0.1	1.15	0.04	-2.22	-1.05	-2.20	-0.27	-7.01	-0.00
195	Cholecystectomy w C.D.E. w cc	50	20001	0100	13.0	14.2	14.3	12.0	13.0	13.0	13.1	12.0	12.0	12.3	12.3	12.2	12.2	11.0	11.9	11.2	11.2	10.0	-4.40	-4.10	-3.07	-2.42	-0.75	-3.20	-5.40	-0.27
197	Cholecystectomy except by laparoscope w/o C.D.E. w cc	50	X	28010	X	X	X	X	X	X	X	X	X	X	X	0.1	0.1	10.0	10.0	0.0	0.0	0.1						22.05	-3.00	4.07
199	Hepatobiliary diagnostic procedure for malignancy	20	3001	2208	10.3	15.5	10.0	10.4	15.4	15.1	10.2	15.3	15.5	14.3	14.4	12.0	13.0	13.4	13.4	12.4	12.4	11.1	-0.04	-1.77	2.07	-7.03	-2.05	-2.02	-7.31	-10.21
205	Disorders of liver except malig, cirr, alc hepa w cc	20	21003	21012	0.0	0.0	0.7	0.0	0.0	0.5	0.5	0.4	0.4	0.1	0.1	0.0	0.1	0.5	0.5	0.0	0.0	7.2	-0.10	-0.00	-0.00	-2.14	-1.23	-0.13	-0.17	-0.20
209	Major joint & limb reattachment procedures of lower extre	80	X	320015	X	X	X	X	X	X	X	11.3	11.3	10.0	10.0	0.7	0.7	0.0	0.0	7.0	7.0	0.7				-0.54	-7.70	-0.03	-12.75	-13.05
210	Hip & femur procedures except major joint age > 17 w cc	80	122740	121002	10.0	10.0	10.1	15.4	10.5	14.7	14.7	13.0	13.0	13.0	13.1	12.1	12.1	10.0	10.0	0.0	0.0	0.0	-3.40	-4.02	-0.00	-0.10	-7.03	-0.03	-10.50	-12.27
211	Hip & femur procedures except major joint age > 17 w/o cc	80	0401	25325	11.0	12.0	12.0	11.5	11.0	10.0	10.0	10.2	10.2	0.4	0.0	0.7	0.7	0.0	0.0	7.1	7.1	0.3	-4.32	-5.04	-0.02	-7.41	-0.20	-0.00	-10.01	-11.00
213	Amputation for musculoskeletal system & conn tissue disor	80	4013	0780	14.7	14.0	14.1	13.7	12.0	13.7	13.0	13.3	13.4	12.0	13.0	12.5	12.0	11.7	11.7	10.0	10.0	0.0	-1.02	0.10	-2.75	-2.00	-2.20	-0.00	-0.31	-0.37
214	Back & neck procedures w cc	80	32260	51202	13.0	14.7	14.0	13.0	12.0	12.6	12.7	11.3	11.4	10.2	10.3	0.2	0.2	0.4	0.4	7.2	7.4	0.0	-0.00	-0.03	-0.00	-10.04	-0.00	-10.44	-12.00	-12.10
217	Wnd debrid & skn grft except hand, for muscskelet & conn	80	0710	10241	10.5	21.0	22.3	22.0	23.0	22.5	23.0	21.0	22.3	21.0	21.0	20.4	20.0	10.0	10.2	17.0	17.0	10.3	2.20	-0.42	-1.10	-0.03	-2.00	-0.00	-10.07	-0.00
235	Fractures of femur	80	0450	0543	14.1	13.0	14.1	13.0	13.0	13.2	13.3	12.3	12.5	11.2	11.0	10.2	10.4	0.0	0.0	7.7	7.7	0.7	-1.01	-4.12	-0.42	-10.52	-7.04	-13.03	-14.04	-12.34
236	Fractures of hip & pelvis	80	40140	27003	10.0	10.1	10.1	10.0	10.1	0.0	0.0	0.4	0.4	0.0	0.0	0.2	0.3	7.0	7.0	7.0	7.0	0.2	-0.05	-2.32	-3.02	-0.42	-7.20	-5.41	-10.72	-0.02
238	Osteomyelitis	80	5010	7520	14.0	14.0	14.7	14.4	14.4	14.1	14.2	14.3	14.4	13.0	13.0	12.0	13.0	12.7	12.0	11.3	11.4	10.1	-1.02	-1.00	1.03	-3.20	-0.00	-1.04	-10.02	-11.21
239	Pathological fractures & musculoskeletal & conn tissue mal	80	90051	90501	10.0	10.2	10.3	10.3	10.4	10.3	10.4	10.3	10.3	10.0	10.1	0.7	0.7	0.2	0.2	0.4	0.4	7.0	1.00	0.10	-0.05	-2.02	-3.10	5.27	-0.07	-0.17
243	Medical back problems	50	152047	70870	7.1	7.0	7.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	-0.04	-0.04	-1.00	-0.14	-1.15	-3.40	-5.00	-0.01
254	Fx sprn strn & disl of uparm lowleg ex foot age > 17 w/o cc	80	5340	0208	4.0	0.3	5.3	5.2	0.2	0.1	0.1	0.0	0.0	4.7	4.7	4.0	4.0	4.4	4.4	4.0	4.0	3.0	-2.22	-1.00	-1.00	-0.17	-3.32	-3.44	-0.17	-2.03
263	Skin graft &/or debrid for skin ulcer or cellulitis w cc	80	20400	20008	20.0	21.7	22.1	22.1	22.0	23.0	23.3	21.0	22.1	20.2	20.0	10.2	10.4	17.0	17.0	10.7	10.0	13.0	1.00	3.00	-3.77	-0.70	-4.00	-7.00	-11.01	-11.00
264	Skin graft &/or debrid for skin ulcer or cellulitis w/o cc	80	2020	3000	10.0	14.0	14.0	13.0	13.7	12.0	12.0	12.0	12.0	11.4	11.4	11.0	11.0	0.0	0.0	0.1	0.1	0.2	-0.24	-0.01	-0.04	-0.71	-3.23	-11.01	-7.30	-7.02
271	Skin ulcers	80	10037	21015	12.1	12.1	12.3	11.7	11.0	12.0	12.7	12.3	12.0	11.0	11.7	11.0	11.1	10.2	10.4	0.4	0.5	0.0	-2.30	7.73	-0.40	-0.40	-2.05	0.53	0.05	-0.00
277	Cellulitis age > 17 w cc	50	03077	70064	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.7	0.7	0.5	0.0	0.2	0.2	7.0	7.0	7.3	7.3	0.7	-0.00	-1.13	-2.00	-3.04	-3.21	-4.42	-7.14	-7.05
278	Cellulitis age > 17 w/o cc	80	0303	20000	0.0	0.0	0.0	0.7	0.7	0.5	0.0	0.4	0.4	0.2	0.1	0.0	0.0	0.0	0.0	0.4	0.4	0.1	-3.00	-2.12	-1.71	-3.70	-2.00	-3.07	-0.00	-5.20
285	Amputat of lower limb for endocrine, nutrit, & metabol diso	80	2534	4080	23.7	23.0	24.1	22.0	23.2	21.5	21.0	20.0	21.1	20.7	21.4	10.0	10.7	17.0	17.7	10.4	10.4	13.0	-3.00	-0.77	-1.70	-1.00	-0.00	-0.24	-12.05	-12.07
287	Skin grafts & wound debrid for endoc, nutrit & metab disor	80	5704	0204	10.4	10.4	20.0	20.0	20.7	20.1	20.3	20.1	20.4	10.7	10.0	10.4	10.0	10.0	10.0	15.0	10.5	13.4	0.00	-2.20	1.30	-0.13	-1.47	0.00	-0.00	-13.04
294	Diabetes age > 35	50	105110	00024	7.0	7.7	7.0	7.0	7.7	7.0	7.0	7.5	7.0	7.2	7.3	7.1	7.1	0.7	0.7	0.1	0.2	0.7	-1.10	-0.01	-1.00	-3.00	-2.02	-4.01	-0.00	-7.70
296	Nutritional & misc metabolic disorders age > 17 w cc	80	215412	210840	7.7	0.0	0.0	0.7	0.7	0.7	0.0	0.0	0.0	0.3	0.4	0.0	0.0	7.0	7.0	7.0	7.0	0.4	1.00	0.21	-1.04	-2.00	-2.00	-0.54	-7.20	-0.20
320	Kidney & urinary tract infections age > 17 w cc	80	152002	100070	0.2	0.0	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.4	0.4	0.1	0.1	7.0	7.0	7.0	7.0	0.4	0.23	-1.07	-0.07	-2.24	-3.02	-0.40	-7.50	-0.50
331	Other kidney & urinary tract diagnoses age > 17 w cc	20	32214	30101	7.0	7.7	7.0	7.7	7.7	7.7	7.7	7.0	7.0	7.0	7.5	7.3	7.3	7.1	7.2	0.0	0.0	0.2	0.77	-1.12	-0.77	-1.70	-1.70	-2.75	-0.20	-0.05
403	Lymphoma & non acute leukemia w cc	20	24047	24012	11.0	11.0	12.1	12.3	12.4	12.2	12.3	11.0	12.0	11.0	12.0	11.2	11.3	10.7	10.0	0.0	0.0	0.3	3.32	0.00	-2.20	-0.00	5.23	4.03	7.07	-0.25
410	Chemotherapy w/o acute leukemia as secondary diagnosis	50	X	05873	X	X	X	X	X	X	X	3.0	3.0	3.0	3.0	3.0	2.7	3.4	3.4	3.2	3.3	2.4				0.22	0.00	-0.05	-2.47	0.30
413	Other myeloprolif dis or poorly diff neopl diag w cc	20	15403	0421	0.0	10.7	10.0	11.1	11.1	11.3	11.4	11.0	11.1	10.7	10.7	10.0	10.7	0.0	10.0	0.1	0.1	0.3	2.00	2.30	-2.24	-3.04	-0.20	-0.71	-0.13	-0.11
416	Septicemia age > 17	80	00434	102132	10.7	10.0	10.7	10.0	10.0	10.7	10.0	10.0	10.0	10.3	10.4	10.0	10.1	0.0	0.0	0.0	0.0	0.2	-0.01	1.40	-0.72	-2.01	-2.02	4.72	-7.40	-7.20
439	Skin grafts for injuries	80	1222	087	13.4	12.0	12.0	12.0	12.3	12.0	13.2	11.2	11.0	0.4	0.0	10.0	10.0	0.5	0.0	0.2	0.3	0.0	1.00	-1.11	-7.00	-20.40	12.30	-0.01	-3.10	-3.15
462	Rehabilitation	80	4020	0380	10.1	10.1	10.5	10.0	10.0	10.0	10.0	10.4	10.0	17.0	17.0	10.0	10.0	10.0	10.7	14.0	14.0	13.0	3.42	-0.04	-0.07	-3.00	-0.27	-1.02	-0.70	-7.57
468	Extensive O.R. procedure unrelated to principal diagnosis	20	X	00840	X	10.3	10.0	10.4	10.0	10.5	10.7	10.3	10.4	10.1	10.1	10.3	10.4	17.7	17.7	10.2	10.0	10.2	10.20	0.44	-0.00	-0.03	1.01	3.40	0.20	-0.30
471	Bilateral or multiple major joint procs of lower extremity	80	2200	0111	20.0	10.5	10.0	17.0	17.0	10.0	10.7	10.7	10.0	14.1	14.1	12.7	12.7	11.3	11.3	0.0	0.7	0.0	-0.30	-7.70	-4.20	-10.01	-0.05	-11.00	-10.00	-10.24
475	Respiratory system diagnosis with ventilator support	50	X	00514	X	13.1	12.2	14.3	14.4	14.1	14.2	14.3	14.3	13.7	14.1	14.2	14.2	13.7	13.7	12.0	12.0	12.1	0.45	-1.70	1.77	-4.50	2.00	3.24	-0.70	-5.83
	average																						0.11	-1.06	-1.02	4.07	-2.21	-0.24	-0.00	-0.20
	count																						67	67	68	61	61	62	62	62

Average Length of Stay
DRG 14 - Stroke



Average Length of Stay
DRG 236 - Hip/pelvis fracture



Prospective Payment Assessment Commission
Public Handout

December 13, 1995

Post-Acute DRGS: Changes in PPS Hospital Length of Stay

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Post Acute-Care
Length of Stay Analysis

- Post-acute care DRGs identified based on HCFA research
- 1991-1994 period examined
- DRGs with less than 300 discharges excluded

Change In Length of Stay For All DRGs, 1991-1994

	1994 Discharges[a] (In Millions)	LOS (Days) 1991	LOS (Days) 1994	Percent Change[b]
National	10.5	8.1	7.1	-13.1%
Urban	8.3	8.5	7.3	-13.6
Rural	2.1	6.8	6.0	-10.8

[a] Numbers do not add due to rounding.

[b] Percent changes are based on non-rounded numbers.

Change In Length of Stay For Post-Acute Care DRGs, 1991-1994

	For All DRGs	Post-Acute Care DRGS
National	-13.1%	-22.6%
Urban	-13.6	-23.5
Rural	-10.8	-18.2

Change in Length of Stay for Selected DRGs, 1991-1994

DRG	LOS (Days) 1991	LOS (Days) 1994	Percent Change*
209 & 491 (hip)			
National	10.1	7.3	-27.9%
210 (hip)			
National	12.4	9.3	-25.1
014 (stroke)			
National	9.6	7.9	-17.8

* Calculations based on non-rounded numbers.

HOMECARE™

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March 1995

THE FAMILY HOME CARE ACT

Home care keeps families together and can be much less costly than care in hospitals or nursing homes. It allows individuals to receive medical, recuperative, and long-term care in their own homes, with their families, and with greater independence and dignity than in institutions.

Various governmental impediments, however, increase the cost of home care, prevent home care from being available to those in need, and create an administrative nightmare.

Enactment of the Family Home Care Act will enable individuals in need of home care to receive high quality, affordable care in the setting they most prefer -- their own homes -- by simplifying and improving the Medicare and Medicaid home care benefits. Specifically, this proposal will:

- Keep families together;
- Eliminate costly and outdated regulations;
- Streamline administration of the home care benefit;
- Use high technology to make the Medicare and Medicaid programs more efficient; and
- Improve the method of paying for home care.

KEEP FAMILIES TOGETHER

1) Allow payment for home health services for those receiving adult day care.

Homebound home care patients are allowed to attend adult day care centers which provide respite to family caregivers and socialization to isolated home care recipients. These patients, however, are not allowed to receive Medicare home care services while at the day care site. This restriction creates a form of institutionalization in the patient's home. Coverage should be maintained for patients who require special transportation or assistance to reach these centers, and Medicare should cover home care services provided to these patients while at the centers.

Extend spousal impoverishment protections to home care.

When a wife places her husband in a Medicaid nursing home, her assets and income are protected to ensure that she does not have to live in poverty herself. However, if a wife enrolls her husband in a Medicaid home care program to enable him to continue to live at home, she must impoverish herself as well.

The Medicaid program requires that in order for the husband to qualify for Medicaid home care benefits, nearly all of the couple's assets and income have to be spent-down. In 1989, Congress allowed the states to extend "spousal impoverishment" protections to home care, but few states have done so. Congress should enact legislation giving Medicaid individuals the choice of staying at home with their spouses, free from financial pressures to enter a nursing home.

3) Exempt home health agencies and hospices that perform simple and routine tests from the Clinical Laboratory Improvement Amendments (CLIA).

Some home care agencies perform simple tests that have been determined to pose no risk to patients and therefore have been waived, such as blood glucose testing using devices specifically cleared by the Food and Drug Administration for home use. Others perform moderately complex tests, such as the prothrombin time test using teststrip meters.

These tests are performed under much safer circumstances than full-service labs because there is no danger of confusing patient test results when each test is performed individually in the patient's home. Tests are administered in the home under physicians' orders by nurses who are regulated by state laws. Subjecting these agencies to federal regulations, certification, and registration designed for traditional laboratories is inappropriate, burdensome, and costly.

4) Limit the application of Medicare regulations only to Medicare reimbursed care.

Currently, patients who pay for home health care out of their own pockets or through private insurance must still have their care plan approved by Medicare if they use a Medicare certified home health agency. Under this system, an elderly person who contracts with a Medicare certified agency even for purely custodial care, like bathing, must have this care prescribed by a physician before it can be provided.

Requiring physician's orders in these cases unnecessarily complicates and delays caregiving and increases costs. Home care nurses are qualified and authorized under state regulations to assess needs for unskilled care, order them, and supervise the staff who perform them. In fact, nurses regularly perform these functions outside the Medicare program.

This onerous regulation should be erased, allowing Medicare certified agencies to care for their non-Medicare paying patients as all other agencies do.

STREAMLINE ADMINISTRATION OF THE HOME CARE BENEFIT

5) Allow licensed practical nurses (LPNs) to supervise home care aides.

Currently, only registered nurses (RNs) can supervise home care aides. Allowing licensed practical nurses (LPNs) to supervise home care aides, under the general supervision of RNs, would allow RNs more time to perform complex and highly skilled nursing services and would result in considerable cost savings to the Medicare program. This would conform Medicare rules to standards of practice as regulated by the states.

6) Allow providers to appeal survey and certification deficiencies.

Home health agencies and hospices are sometimes unfairly accused of not complying with the Medicare Conditions of Participation even when they are fully in compliance with these requirements. Agencies may experience public notice of termination from the Medicare program and a requirement to transfer all Medicare patients, prior to review by an Administrative Law Judge (ALJ). Agencies have no formal appeal right in cases where HCFA does not threaten termination, even though the agency may be subject to significant costs and operational changes in correcting nonexistent deficiencies.

Providers should have the opportunity to request a reconsideration of deficiency citations which they believe to be incorrect, and agencies should not be required to submit a plan of correction or take corrective action until the reconsideration has been made. The HCFA Regional Office should review these requests and report its conclusions and supporting rationale to the provider in a timely manner. If the Regional Office reaffirms the surveyor's initial decision, ALJ appeals should be available for all deficiency determinations and no sanctions should be imposed before final appeal decisions are rendered. Of course, deficiencies judged by the state survey agency to involve an immediate and serious threat to patient safety would have to be corrected immediately, pending review by the Regional Office.

7) Permit direct provider appeal rights.

Home health agencies and hospices are not allowed to appeal all Medicare decisions that result in financial liability for the agency or otherwise adversely affect their status with the Medicare program. For example, agencies cannot appeal claims that are denied, but paid under the waiver of liability, even though those claims are counted against the agency's error rate. In addition, providers cannot appeal claims that are denied on technical grounds, such as insufficient physician's orders, nor can they bill patients in these cases. Congress should allow direct provider appeals of all claims where the agency may be harmed.

STREAMLINE ADMINISTRATION (cont.)

8) Implement informal cost report reimbursement appeals.

Increasingly, intermediaries have been arbitrarily and improperly disallowing costs for which home health agencies are requesting reimbursement. Agencies have only two options in appealing these adjustments. Agencies may request: (1) a hearing with the intermediary when the claims involve less than $10,000, or (2) a formal hearing at the Provider Reimbursement Review Board (PRRB) for claims in excess of $10,000. A PRRB appeal is very costly, and there is a substantial backlog of cases leading to long delays. For claims in excess of $10,000, Congress should create an informal appeal at the intermediary level similar to that which is available for Medicare coverage determinations.

9) Improve access to judicial review for Medicare claims.

Congress should allow class action judicial review of Medicare claims involving widespread practices of intermediaries, regional policy interpretations, and challenges to the validity of regulations, without requiring that each party in the class exhaust all administrative remedies. This would eliminate multiple administrative appeals on the same issue and would benefit all affected individuals, regardless of their ability to access the appeals process.

10) Coordinate the OBRA87 training requirements for home care aides and aides in nursing facilities.

Congress should require the Department of Health and Human Services (DHHS) to coordinate the aide training and testing programs for home health agencies and nursing facilities found in the Omnibus Budget Reconciliation Act of 1987 (OBRA87), providing a core subject area that overlaps both home and institutional settings while recognizing the differences in these settings. This would reduce costs by eliminating duplicative and costly certification programs for aides, give aides wider employment opportunities, and give providers greater access to properly trained paraprofessional caregivers.

STREAMLINE ADMINISTRATION (cont.)

11) Require that home care agencies must not only train, but test new home care aides to ensure high quality care and require Medicare to reimburse agencies for these costs.

Medicare certified home health agencies must meet requirements relating to the training and testing of home care aides. The Medicare program should reimburse agencies for the costs of training and testing programs. In addition, Congress should clarify that both training and competency testing is required of nurses aides and home care aides. Under current law, home care aides who complete a competency evaluation program, but are not tested, may work for a Medicare certified home health agency. This measure will help ensure that all providers are properly trained, tested, and supervised.

12) Require cost-effective and sensible systems for ensuring that Medicaid is payor of last resort.

Under pressure to cut their Medicaid budgets, many states are demanding that home health agencies review old claims that Medicaid has paid and submit the claims to Medicare. Under this system, agencies are required to retroactively develop the necessary paperwork to submit the claims to Medicare -- often numerous times due to appeals. If Medicare agrees to pay these old claims, the providers must reimburse the Medicaid agencies the amount that Medicaid paid for those services and wait for Medicare to pay the agencies. This ungainly system, known as "Medicare maximization" or "third party liability (TPL)," is costly and inefficient for all parties -- Medicaid, Medicare, and the home care agencies.

States should be required to use more cost-efficient and sensible systems to ensure that Medicaid is the payor of last resort. And payments should be made directly by Medicare to the Medicaid program.

USE TECHNOLOGY TO MAKE MEDICARE AND MEDICAID MORE EFFICIENT

13) Provide access to Medicare and Medicaid HMO enrollment information and incentives for agencies to care for HMO patients.

Currently, a home care agency has no way to know if a patient who comes to them is already enrolled in an HMO. In many cases, the agency may accept the patient, provide care, and submit for Medicare or Medicaid reimbursement only to be penalized for improperly billing because the patient belongs to an HMO. However, agencies are denied access to up-to-date HMO enrollment information and instead are limited to asking patients and patients' families for enrollment information, which is often incorrect.

Agencies who care for HMO patients in the absence of up-to-date information need to be held harmless in cases where they treat patients only to later find out that the patient was enrolled in an HMO.

14) Require a national data base for home health agency executive compensation.

HCFA uses outdated, unreliable, and inconsistent data to determine compensation for agency administrators. Some intermediaries use data from the 1970s. HCFA should develop a standard up-to-date method of determining administrator compensation.

IMPROVE THE METHOD OF PAYING FOR HOME CARE

15) Develop and test a fair and equitable prospective payment system (PPS) for home care.

In developing a prospective payment system (PPS) for home health agencies, Congress should ensure that the system is equitable for the home health industry as a whole. A PPS must take into account such crucial pricing factors as the medical acuity of an agency's patients and travel time requirements. In addition, any PPS should provide for a predictable payment schedule while minimizing administrative burdens on agencies.

A PPS that pays a flat amount per-visit penalizes agencies whose visit costs are high because their patients need more intensive care or because their patients are located in hard-to-serve locations. Per-visit PPS also penalizes low-utilization agencies (i.e., agencies that provide relatively few visits per patient). Although these agencies provide home care at relatively low cost to the federal government, their per-visit costs tend to be high because they have fewer visits over which to spread the costly initial assessment visit and other fixed costs. Finally, a per-visit PPS could actually increase Medicare expenditures since the incentives in a per-visit PPS are to increase the number of visits. Profits are tied to visits, so the more visits an agency makes, the more profits it earns.

Congress should require DHHS to develop an accurate adjustment for patient acuity, transportation and security costs, labor and other costs as a necessary step toward developing a fair and equitable prospective payment system for home care.

16) Include hospital-based agencies in the home care data base.

One-quarter of all home health agencies are hospital-based. Until recently, Medicare paid hospital-based home care agencies a higher rate of reimbursement than other home health agencies, based on hospital accounting systems. This differential was eliminated in the last Congress. While the differential was in place, the costs and data needed to reimburse hospital-based agencies were kept separate from the costs and data for all other home care agencies. Medicare home care payment rates are based on this data.

Now that the reimbursement for all home care agencies is based on the same data, the hospital-based agency data needs to be added to the reimbursement data base. Continuing to exclude hospital-based home health agency data from Medicare reimbursement calculations leaves one-quarter of the home health industry unaccounted for.

IMPROVE THE METHOD OF PAYING FOR HOME CARE (cont.)

17) Maintain the waiver of liability and presumptive status for home care and hospice providers.

A waiver of liability protects home health and hospice providers who, in good faith, render services to individuals who are ineligible for Medicare or who receive services later determined to be not covered. Under this waiver provision, providers are presumed to have acted in good faith if they demonstrated a reasonable knowledge of coverage standards in their submissions of bills.

The waiver and presumption provisions, however, expire on the last day of 1995. Congress should indefinitely extend both the waiver of liability and presumptive status for home health and hospice providers.

18) Eliminate the lesser-of-cost-or-charges provision.

The lesser-of-cost-or-charges provision (LCC) limits aggregate Medicare home care payments to the providers' charges or costs, whichever is less. In some cases under this provision, Medicare payments would not cover the costs of providing services. In order to recoup these losses, some agencies may try to shift costs to private pay patients.

LCC should be eliminated because it: fails to achieve significant Medicare savings; is inequitable to an agency's private pay patients; prevents certified agencies from competing on an equal footing with noncertified agencies; and is inflationary.

19) Develop alternative payment methods for extended care.

Medicare bases its reimbursement on average visit costs for all patients, Medicare and non-Medicare. Yet, in some instances, there are significant differences between the costs of visits for Medicare and non-Medicare patients. For example, elderly Medicare patients might require substantially longer home care aide visits than younger non-Medicare patients.

Congress should mandate that HCFA implement demonstration projects for alternative payment methods that take account of differences between the average per-visit cost of Medicare and non-Medicare patients. The demonstration projects should study the benefits and costs of alternative methods such as "per hour" or multiple level "per visit" payment systems.

Thank you.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. If there are no additional questions, I want to thank the panel very much. I look forward to working with you as we attempt to create a prospective payment system that not only meets our needs but that we can convince CBO saves some money, as well.

Thank you very much.

Mr. HOLT. Thank you.

Mr. HOFFMAN. Thank you.

Ms. CUSHMAN. Thank you.

Chairman THOMAS. Our last panel for the day will be Susan S. Bailis, president and chief operating officer, of the ADS Group in Massachusetts and she's on behalf of the American Health Care Association; John McMeekin, president and chief executive officer, Crozer-Keystone Health System, Media, Pennsylvania, and the American Hospital Association; and Laurence F. Lane, president, National Association for the Support of Long-Term Care.

All of your written testimony will be made a part of the record and you can inform us any way you see fit. Ms. Bailis, you may begin.

STATEMENT OF SUSAN S. BAILIS, PRESIDENT AND CHIEF OPERATING OFFICER, ADS GROUP, NEWTON, MASSACHUSETTS, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION; ACCOMPANIED BY ROBERT DEANE, PH.D., CHIEF ECONOMIST, AMERICAN HEALTH CARE ASSOCIATION, AND ROB HARTWELL, FORMERLY STAFF OF WAYS AND MEANS COMMITTEE, U.S. HOUSE OF REPRESENTATIVES

Ms. BAILIS. Thank you, Mr. Chairman.

Mr. Chairman, and Members of the Subcommittee, I am Susan Bailis, president and chief operating officer of the ADS Group of Massachusetts. I am accompanied today by Dr. Robert Deane, chief economist of the American Health Care Association and Rob Hartwell, who formerly worked for your Committee.

Almost a year ago, I testified before your Subcommittee and I applaud you for holding today's hearings on prospective payment for post-acute services, a critical followup on a critical Medicare issue.

I am speaking today on behalf of the American Health Care Association, a federation of 51 affiliated associations representing over 11,000 long-term care providers. I also serve on the Prospective Payment Assessment Commission but let me clarify now that I am only speaking as a provider and as an officer of AHCA.

We support the full implementation of an acuity and case-mix adjusted prospective payment system by October 1, 1997. The prospective payment system should incorporate payments for all services provided during the benefit period based on patient needs rather than site of service and we support a targeted approach to repealing the 3-day prior hospital stay.

All of these proposals are in harmony with your approach to reforming Medicare. In a free market, where patients and independent case managers can make informed choices for care, nursing facilities can offer skilled care of high quality at a cost far below comparable acute care settings.

Even in fee-for-service Medicare, according to Bruce Vladeck, the cost of SNF care is an average of 58 percent less than in an acute-based SNF setting. Perhaps more startling is according to our recent studies, our patients are older and sicker than in hospital-based skilled nursing facilities. And the challenge we face is how to best maximize the use of post-acute care to ensure quality and achieve significant cost savings.

One good example is to follow the lead of the private sector in managed care. Managed care has gone a long way in reducing hospital stays by substituting SNF subacute care for acute care days. As you can see on the chart, on my right, you can see the hospital days in the top line coming down, SNF days going up. This is actual experience at Pacifix Care in a Medicare risk program.

And ProPAC in its discussions has confirmed the substitution effect. That is to say, subacute care at a lower cost substitutes for acute care. With 10 percent of Medicare beneficiaries now in Medicare risk contracts and many more coming on, this is clearly a trend.

Just to summarize, we agree with you that there is significant growth in SNF care, as a result of the Catastrophic Act and the clinical coverage guidelines changes in the late eighties. In addition, between 1989 and 1995, as a result of taking patients out of the hospital earlier, the acute length of stay for certain subacute DRGs has gone down by 31 percent. You can see on that chart over there the top line is actually payment going up by 9 percent and the bottom line is the length of stay going down 31 percent, again, for subacute DRG.

So, we believe that the decrease in length of stay is fueled by the availability of subacute care. And clearly, what this says is that payment reform is needed in both the hospitals and the SNF sectors in order to align incentives.

The American Health Care Association endorses prospective payment for SNFs, endorses a fully developed case mix and acuity adjust prospective payment system that covers episodes of care covering all SNF services. Payment should be based on patient needs.

We do not believe that the administration's proposal, which is a per diem proposal, effectively does what's necessary in terms of really controlling costs and providing adequate care. We have hired Price Waterhouse to work on developing an episodic prospective payment system and believe that we will be ready to perfect this system and see implementation for all SNF services by January 1, 1998.

We have other recommendations including post-acute care to save money by recalibrating hospital DRGs. That issue has come up earlier in the discussion. We believe bundling will not be successful in trying to save Medicare moneys and we believe that the 3-day prior hospital stay should be modified. We believe in consolidated billing and extending the waiver of liability and monitoring the OBRA 1995 enforcement rules as a way of ensuring that Medicare dollars are effectively spent.

Thank you for the opportunity to testify and I welcome any questions you may have.

[The prepared statement and attachments follow:]

STATEMENT OF SUSAN S. BAILIS, PRESIDENT AND CHIEF OPERATING OFFICER
THE ADS GROUP
ON BEHALF OF
THE AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Members of the Subcommittee, I am Susan S. Bailis, Executive Vice President and Chief Operating Officer of The ADS Group of Andover, Massachusetts. I'm accompanied today by Robert Deane Ph.D, Chief Economist with the American Health Care Association, and Rob Hartwell, who formerly worked for your Committee. Three Hundred and Sixty Two days ago exactly, I testified before your Subcommittee, and I applaud you for holding today's hearing on Prospective Payment for post acute care services - a critical follow-up on a critical Medicare issue.

I am speaking today on behalf of the American Health Care Association (AHCA), a federation of 51 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. I also serve on the Prospective Payment Commission, but let me clarify now that I am speaking only as a provider and as an officer of AHCA.

Let me again, commend you, Mr. Chairman, for your efforts to expand the scope of America's thinking on Medicare and to truly tackle the critical problem of ensuring the program's solvency and improving the delivery and cost-effectiveness of its services. The task you are undertaking to restructure Medicare and improve the program are daunting, but from our preliminary view of where you are heading, it appears you are up to the task. Increasing options for seniors, reducing regulatory barriers to cost-effective care, and stimulating patient responsibility for savings and choices in care are critical. AHCA joins you in embracing these goals.

We support the full implementation of an acuity and case-mix adjusted Prospective Payment System (PPS) by October 1, 1997; the PPS should incoporate payments for all services provided during the benefit period based on patient needs rather than site of service; and, we support a targeted approach to repealing the 3-day prior hospital stay requirement. All of these proposals are in harmony with your approach to reforming Medicare.

In a free-market, where patients or independent case managers can make informed choices for care, our nursing facilities can offer skilled nursing care of the best quality available and at costs far below a comparable acute care setting. Even in Medicare, according to HCFA Administrator, Bruce Vladeck, the cost of free-standing SNF care is an average of 58% less than in an acute-based setting.[1] Perhaps more startling, is that according to most recent studies, our patients are older and sicker than those in acute-based SNF facilities. The challenge you face, is how to best maximize the use of post acute care to ensure quality and to achieve significant cost savings. One good example is to follow the lead of the private sector and managed care.

POST ACUTE CARE: BENEFICIAL TO THE CONTINUUM

PRIVATE SECTOR EXPERIENCE: SKILLED NURSING CARE UNDER MANAGED CARE

As you examine ways to find cost savings, then obviously you will closely scrutinize managed care. I highly recommend you examine how managed care is utilizing skilled nursing care to reduce acute care stays. Managed care has recognized the benefit of substituting SNF days for more expensive hospital days. In testimony before the Prospective Payment Commission, Dr. Roger Taylor, a Member of the Physician Payment Review Commission, and former Executive Vice President with PacifiCare, one of the fastest growing managed care organizations in the nation, stated that a large percentage of their ability to save money was their ability to reduce hospital Medicare days per thousand through the utilization of SNF day substitution.

In fact, if you will refer to the **chart titled "Sicker and Quicker"**, you will see that PacifiCare has achieved a large part of its savings by reducing hospital stays from 1089 days per thousand members in 1990, to 964 in 1993, through correspondingly increasing their SNF days per thousand from 497 to 676.

[1] Testimony submitted for the record by HCFA Administrator Bruce Vladeck to the Subcommittee on Health, 9/19/95.

Currently, 4.5 million Medicare recipients or over 10% of all eligible beneficiaries are enrolled in managed care plans. Fully 76% of these beneficiaries are in risk contract plans and participation in these plans during 1994 increased by 16%. According to ProPAC, risk contract patients use hospitals less and hospital lengths of stays are much shorter. Conversely, they utilize SNFs at a far greater rate. The reason: Substantial savings. ProPAC confirms this on Page 72 of their 1995 report where they write:

> *"Beneficiaries in risk contracting HMOs were just as likely to use hospital, physician, and home health services as their fee-for-service counterparts, but they used fewer of them, according to the program's 1992 evaluation. This was not true, however, for nursing home use. HMO enrollees were likelier to use a skilled nursing facility, although the length of stay was similar to that of FFS beneficiaries. Apparently, plans were not limiting access to ambulatory and inpatient services, but were using skilled nursing facilities in place of some hospital days."*

AHCA supports the utilization of managed care to provide quality care and control costs. In particular, we commend the Congress for extending and expanding the Medicare Select Demonstration Project and for exploring ways to increase Medicare beneficiaries in managed care risk contracting. We believe the move by Congress to reexamine the entire Medicare program and its relationship to private sector efforts in managed care are welcome and will be fruitful.

In Orange County, California, where over 50% of Medicare eligible residents are enrolled in managed care risk contracts, artificial barriers that drive up costs - such as the 3-day stay rule - are avoided, and consumers are pleased with their coverage and care. The ability of managed care organizations to achieve cost savings by utilizing SNFs is something the Congress must examine. Follow the lead of the private sector and market-based reforms, and I believe you will find it easier to control Medicare costs.

POST ACUTE CARE UTILIZATION IN MEDICARE

Let me now discuss briefly why post acute care utilization is increasing significantly in Medicare. It can be easily summed up by examining the chart on reduced hospital stays in subacute DRG categories. Since 1989, acute lengths of stay have declined by 31% in 62 DRGs with substantial subacute care utilization. During the same time span, average DRG payments for these 62 DRGs increased by 9%.[2] Clearly the DRG system has encouraged the movement of acute care patients into post acute care settings resulting in substantial growth in post acute care. Unfortunately, unlike the private sector, Medicare does not maximize potential savings because the DRG payments have not been properly adjusted to reflect the reduced length of acute stays. If this were done, Medicare would be able to substitute post acute care for a portion of the current DRG payment, saving as much as $9 billion per year!

Mr. Chairman, the American Health Care Association is today releasing detailed length of stay and DRG payment data we think is critical and ask that it be inserted into the hearing record. Copies have been distributed to each Member prior to the hearing.

Clearly, prospective payment reforms that I will discuss today are critical, but so too are the reforms of the acute care payment system necessary to maximize the utilization of post acute care, to reduce costs, and to reflect trends in the private sector and managed care. Reforming one side of the equation without the other, especially if deficit reduction is the driving force, fails to address the fundamental flaws of the acute care payment system, which contributes to increases in post acute utilization, without maximizing potential savings.

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[2] Does not include additions to standard payment for post acute care DRGs, including outlier, disproportionate share and teaching hospital payments.

In a free-market environment, where seniors have the option to participate in different federal plans that offer a variety of benefits, including the current program, skilled nursing care will thrive as it has in managed care. In the marketplace today, subacute care is a reality. In fee-for-service Medicare, it is not fully understood. In the marketplace, there is no three-day prior hospital stay. In Medicare, the three-day stay rule costs the program significant resources. The positive role of subacute care in Medicare has not been fully acknowledged.

We eagerly await the elimination of unnecessary and burdensome rules, regulations and barriers to competition in the current fee-for-service program. In fact, we have specific and long-standing proposals that fit in with what you are attempting to accomplish. Let me outline some of our proposals, beginning with Prospective Payment, which address cost containment and program reforms which are of the utmost importance in attaining a balanced budget.

AHCA COST CONTAINMENT PROPOSALS

PROSPECTIVE PAYMENT

The subject of today's hearing, Prospective Payment Systems (PPS) for post acute care, is one our industry has been working on for at least 14 years. AHCA had adopted as our policy, a model PPS system based on a per diem payment adjusted for a facility's patient case mix, with a capital factor added in and ancillary services passed through. After six years of discussing this with the Congress, and after five different requests from Congress to HCFA to develop a skilled nursing facility PPS, Congress communicated to us in August of 1995 that our per diem system was not the most desirable system from their perspective.

Due to the substantial growth in the utilization of ancillary services, and little if any controls on such growth, Congress, working with ProPAC, requested we move to an episodic based PPS system. Such a system was outlined in the House-passed budget reconciliation bill and we gathered the entire industry to see if we could shift gears from per diem to episodic and went to work on a new system at your request.

The proposal began to take shape in the Conference Report on the Balanced Budget Act of 1995, where we agreed to move to an episodic system and supported the Roth Senate amendment improving on the House and Senate-passed bills and somewhat mitigating the potential damage from interim price controls on ancillary services, directly attacking our ability to compete in the subacute Medicare marketplace. The industry has continued to work on perfecting and expanding the PPS to ensure it will adequately ensure quality, appropriate reimbursement, and include critical factors important to patient care and cost savings.

The industry-backed proposal, now being scored by the Congressional Budget Office, calls for redesigning the Medicare SNF payment system from a retrospective cost-based system to a prospective payment system (PPS), based on:

- Fixed payments for episodes of care covering all services provided during a Part A Medicare SNF stay;
- Payments covering all SNF costs, including routine, ancillary (non-routine) and property costs;
- Reimbursement specific to the individual patient's diagnosis, acuity or case-mix, and covering the full continuum of post-acute, subacute and rehabilitation classifications;
- Payments based on diagnosis and not the location of the delivered services other than geographic region;
- Payments adjusted for local market costs and the cost of facility construction;

- Policies that encourage SNFs to offer higher acuity services and which include sound outlier payment structures addressing cases of extraordinary costs;

- Full recognition of the high costs for the highest acuity SNF patients, including any interim system that is considered;

- Reports on patient outcomes, outlier policies and a move toward an outcome-based quality system vs. the rigid and nearly unworkable OBRA standards in effect at present. Consideration must be given to incorporating a quality of care feedback mechanism in SNF rate setting;

- Policies to reflect intra-SNF transfers during covered stays and ensuring payments are made on the patient classification most accurately reflecting the care provided during the spell of illness at the end of a covered stay; and,

- Recognition of the need for a continuation of the current low-volume SNF PPS.

I want to express our appreciation, Mr. Chairman, for the support from your subcommittee for our proposal in the past, and to ask for your support for our industry proposal now being considered by your Subcommittee and the Congressional Budget Office. In particular, your support, along with Congressman Cardin's, has been very helpful in moving HCFA forward towards our proposal. It is our understanding that they have nearly completed a system to present to your subcommittee. Our major concern, with their proposals, as well as the interim Balanced Budget Act proposals, is the reliance on price control mechanisms or policy changes that will keep us from competing in the higher acuity, or subacute marketplace. Proposals to eliminate the exceptions process allowing for reimbursement for higher acuity patients above the routine cost limits, without fully accounting for case-mix or patient acuity, would devastate our ability to compete in the subacute care marketplace and eliminate the potential for billions in savings to the program.

Another major concern is the Administration's desire to continue to subsidize less efficient and more costly hospital-based SNF care. Your proposal moving to an episodic-based system would dictate payment based on patient needs, not the site of the services provided. Hospital-based SNFs, which cost Medicare an average of $435 per day, compared to $275 per day for freestanding SNFs, already have numerous advantages, which clearly growth patterns demonstrate are being exploited. For instance:

- routine cost limits that are over $80 per patient per day more than for freestanding SNFs;

- new provider exemptions to the RCLs are granted to new facilities entering the skilled nursing Medicare program and that have never before provided a skilled level of care. Exemptions are usually granted for three years. Of the 3035 exemptions granted between 1990 and 1994, 61% were to freestanding facilities and 39% to hospital-based SNFs, representing a disproportionate share of exemptions.

- the ease which hospitals are able to obtain exemptions is also of major concern. HCFA does not recognize the provision of acute care as prior skilled nursing service in determining whether a facility is newly entering the program. Therefore, hospitals can set up SNFs providing skilled care and claim these are new services - freestanding SNFs cannot.

- excess capacity that is easily converted from acute to SNF beds as little capital, unlike building a freestanding SNF, is needed;

- incentives for hospitals to allocate labor, administrative, and general costs over to PPS-exempt SNF units (one Executive identified $50,000 per bed as a common figure); and,

- the ability of hospitals to receive a cost-based payment higher than a freestanding SNF in addition to the full DRG payment, when patients are discharged early from an acute bed;

These factors help to explain the significant growth in hospital-based PPS-exempt units. ProPAC estimates that **hospital-based SNFs have grown by over 200% over the last 8 years, while freestanding SNFs have grown by only 29%.**

This being the case, one would think there is some justification for the "six subsidies" of higher reimbursement and policy advantages granted to hospital-based SNFs. There is none! In particular, a December 1995 study entitled "A Comparison of Hospital-Based and Freestanding Nursing Facilities" conducted by a Joint Legislative Committee based on data collected by the Florida Agency for Health Care Administration, determined that "hospital-based and freestanding nursing facilities provide similar services and treat patients that are comparable."

The study of over 68,000 discharges from both hospital-based and freestanding SNFs found that:

- Patients admitted to freestanding SNFs are older than those admitted to hospital-based SNFs;
- Patients admitted to both SNF types have similar DRG codes, with freestanding SNFs taking more heart failure, shock and chronic obstructive pulmonary disease patients;
- Freestanding SNF patients are sicker on average than hospital-based SNF patients, based on an APR-DRG "extreme" severity of illness level of 19.6% to 15.2%;
- Freestanding SNF patients, due to there higher acuity, are more likely to die and correspondingly have fewer discharges to the home;
- The risk of death (outcomes) "for hospital-based nursing patients is statistically identical to that of nursing home patients once adjustments are made for mortality level, age, nursing home length of stay, and cancer."

One other recent study, "Rehabilitation Outcomes by Site of Service: A Comparison of Hospitals to Subacute Care Units of Freestanding Skilled Nursing Facilities," also found that SNF rehabilitation patients had lower Functional Independence Measure (FIM) scores and thus were more impaired. The study also found identical changes in functional improvement for both settings, again finding freestanding SNF patients have higher acuity than acute-based SNF patients with identical outcomes.

Any PPS for SNFs must therefore eliminate artificial subsidies and base payment on patient needs, adjusting payment for acuity and case-mix, but not for the site of services provided. Under this methodology, competition will thrive and if facilities have sicker patients, the higher costs will be recognized. AHCA recommends that Congress examine Medicare SNF costs and growth for hospital-based and freestanding SNFs in states where the Certificate of Need (CON) process has been eliminated, to determine if state CON laws stem the rapid growth in the conversion of more expensive acute beds to SNF beds.

In addition to these concerns, we are concerned that the Resource Utilization Group (RUG) patient classification system does not include the full array of SNF services, especially those in many subacute care DRG categories. RUGs III in particular is examining many rehabilitation SNF services, but is not nearly comprehensive enough to cover the full continuum of SNF services. RUGs III may provide some assistance on a per diem system, but it does not provide an accurate assessment of resource needs in the case of an episodic system. RUGs III is based upon activities of daily living (ADLs) which are primarily CNA functions, which do not address medical severity.

Once again, the private sector is far ahead of HCFA in this regard. Many of our leading companies have developed detailed assessment protocols which they are using to great success in the marketplace, especially for managed care patients. The reluctance of some health care policy experts to acknowledge the capability of moving to a fully developed PPS based on episodes of care is not surprising, given the inability to develop even a rudimentary per diem PPS over 14 years.

In many ways, this reminds me of the naysayers and doomsayers back in the early 1980's when the hospital DRG system was first proposed. Yes, it has needed fine tuning, and, yes, it has not compensated for reduced stays, but it has not caused the earth to move or wreaked a widespread plague upon our citizens either.

We also note that the Administration's proposal does not fold in ancillary services or capital into the per diem payment. In this case, we question whether it addresses your major concerns on the increased utilization of ancillary services. Perhaps our largest frustration, and one that you probably share, is that Congress has at least five times requested, most recently in OBRA'90 and again in OBRA'93, that we move to a PPS by October of 1995. HCFA promised the House Ways and Means Committee in testimony during late 1993 to have an interim system to the Congress by June of 1994.

Rather than waiting again, AHCA has joined with the National Subacute Care Association in hiring the accounting firm of Price Waterhouse to work with a joint industry PPS "Oversight Committee" to develop a new PPS system that meets your goals of cost containment and quality. It is absolutely critical that patient needs are adequately assessed in developing a patient classification system. The system must take into account not only the diagnosis but also medical severity (i.e. comorbidities), and functional and behavioral factors.

We are meeting continuously to generate the data needed to develop an episodic-based system and to work toward setting up a PPS reflecting our desire to compete in a market oriented post acute continuum. In the interim, HCFA should consider revising its Minimum Data Set (MDS) data base to include medical severity, comorbidity and functional behavior data in order to facilitate efforts to develop a system to assess patient resource needs in any episodic PPS. This PPS Oversight Committee will offer the "finishing touches" on the industry proposal currently in your possession toward the end of year, in time for study and deliberation during 1997 and implementation by January 1, 1998. Administrator Vladeck has committed to us to implement a system by that time and we are hoping it will be jointly developed by the industry, the Congress and HCFA, based on the Price Waterhouse and Oversight Committee's work.

Our model PPS is designed to promote quality care; to ensure equal access for high-acuity beneficiaries; maintain adequate capital formation to address future demographic trends; and to achieve cost containment. It will also easily allow you, in one clean and concise stroke, to reduce reimbursement across the board on all nursing services, eliminating incentives to increase ancillary service utilization, by a percentage, thus allowing you to obtain savings required to balance the budget.

MAXIMIZE SAVINGS FROM SUBACUTE CARE

A report by Abt Associates, Inc. issued in June of 1994, identified 62 DRGs where SNFs are currently providing subacute care and estimated potential cost savings to Medicare if percentages of patients in these groups were treated in SNFs rather than in hospitals. Abt found a potential savings to Medicare of between $7.535 and $8.906 billion per year depending upon the accounting for empty hospital beds and partial waiver of the 3-day stay rule.

I recommend that the Subcommittee examine the Abt report in detail, along with our data submission on DRG payments and acute lengths of stay, to see how legislative initiatives proposed by AHCA could potentially save billions of dollars to the Medicare program. In short, as SNF spending increases on Medicare subacute care, there is a corresponding decrease in acute care spending, especially for outlier patients. The question for you, is how to maximize the potential of this savings stream?

AHCA proposes that hospital subacute DRGs be examined and recalibrated according to severity of illness and length of stay. Particular attention should be paid to the relative costs of SNF subacute care compared to hospital-based subacute care. For instance, HCFA's estimate released last year found that hospital-based SNF care is on average $150 per day more expensive than identical care in a free-standing SNF.

MODIFY THE THREE DAY HOSPITAL STAY RULE

It is absolutely clear, however, that SNFs can provide subacute care at substantially lower costs than hospitals, and in many case, as a direct substitute for hospitalization. In order to test this, AHCA proposes that the Secretary of Health and Human Services immediately waive the 3-day hospital stay requirement for patients in a group of five DRGs, including skin ulcers and chemotherapy, and achieve an estimated $500 million per year in savings in just a few years. For chemotherapy alone, our analysis of HCFA data found that lengths of stay declined by 7.1% from 1989 through 1995, while the DRG payment increased by 48%. Bypassing a hospital stay altogether, which Abt Associates, Inc. estimates could take place half the time, would save Medicare between $2,700 and $4,000 per patient. The SNF stay would be allowed only as a substitute to an acute stay as certified by the admitting physician.

AHCA proposes pilot legislation to explore these cost-savings concepts, gradually expanding the list of DRGs to maximize savings after trial periods with data collection and analysis. The Secretary actually has this authority under current law, but should be required to begin this process as soon as possible.

CONSOLIDATED BILLING

In order to respond to reports of billing abuses by providers of services in SNFs, AHCA proposes to eliminate all third-party billing for Part A services under Medicare and provide SNFs with an option to bill for all Part B services as well. The vast majority of abuses outlined by the General Accounting Office and the Inspector General involved over-charging and fraudulent billing for services provided under arrangement between outside providers and SNFs. AHCA's proposal will require point of service billing and that SNFs directly oversee the provision of services to our patients, verify the services were truly provided for, and bill for these services directly. It is our responsibility to ensure billing in our facilities is accurate and honest and we intend to do so.

FRAUD AND ABUSE

In addition to developing proposals, such as consolidated billing that discourages fraud and abuse in our industry, AHCA has been actively working to eliminate fraud and abuse from the health care industry in general. AHCA is a founding member of the Coalition of Health Associations United Against Fraud and Abuse, which consists of 17 health care associations who are working with Congress and the Administration to eliminate fraud and abuse. The Coalition has developed an anti-fraud and abuse proposal and is actively seeking its enactment by the Congress.

The proposal is based on the following tenets:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;

- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;

- Protect Federal health care programs from unnecessary cost, utilization, and failure to deliver appropriate levels of care;

- Be appropriate for the changing health care market; and

-Separate willful from technical violations.

The Coalition's proposal will go a long way toward eliminating fraud and abuse from the health care industry by combining tough enforcement against those who intentionally violate the law, with education for those who seek to provide care within the complex rules of Medicare and Medicaid.

POST-ACUTE CARE BUNDLING: ANTI-FREE MARKET, ANTI-QUALITY

One recommendation that was suggested as an option by the House Budget Committee in 1995 was bundling all post-acute care services into the hospital DRG system. This is an extremely flawed and unreasonable proposal which would not obtain the cost savings estimated by the Congressional Budget Office. Chairman Thomas, your opposition to the proposal is very much appreciated and warranted. For example:

- Post-Acute care was designed to reduce higher acute hospital costs - the bundling proposal would shift services back to higher cost centers

- providing acute care providers with the control of post acute care services would be a mistake as these providers traditionally have a poor understanding of how to best utilize post acute care

- freestanding SNFs and home care are cost effective alternatives to hospitals - this proposal would encourage continued institutionalization in acute settings, contrary to the intent of the hospital PPS system

- SNFs and home care offer free-market options for consumers - this proposal eliminates competition for services by bringing all services under hospital control

- HCFA is years away from having the data to implement such a system - HCFA has taken 12 years to developing a still to be seen PPS for SNFs

- Hospitals are ill-prepared and do not have the immediate service capacity to offer cost effective post acute services

- This is an antiquated proposal that has found little support - studies show serious design and accountability problems with such a system. A bundling system of this type is unworkable.

Bundling in theory may sound like it makes sense. In fact, as proposed in the House, it would strike at the heart of free-market competition, access to care and most importantly, quality of care. Hospitals would attempt to dump costly outlier patients on SNF, rehab and Home Health providers that would have to refuse to take these patients they could not possibly afford to take with a DRG add-on. Much less one reduced by whatever the hospital determines to be a reasonable mark-up or administrative charge. The proper way to achieve savings is to substitute post acute care for acute care wherever possible and to recalibrate DRG payments to reflect reduced lengths of stay and severity of illness.

RELATED MEDICARE RECOMMENDATIONS

Let me briefly make a few final recommendations to the Committee before wrapping up. These include:

- extend the waiver of liability provisions protecting innocent providers who make unintentional coverage mistakes

- allow providers to make reasonable and customary charges for services rendered under the related party rules

- oppose HCFA attempts to "fully certify" Medicaid and Medicare beds in nursing facilities. This proposed policy could lead to upcoding and over-utilization due to the huge number of new Medicare beds that would be made available for services. The potential cost of this proposed rule should be examined closely by this Committee

- carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, are not abused by over-zealous inspectors and are enforced fairly and evenly

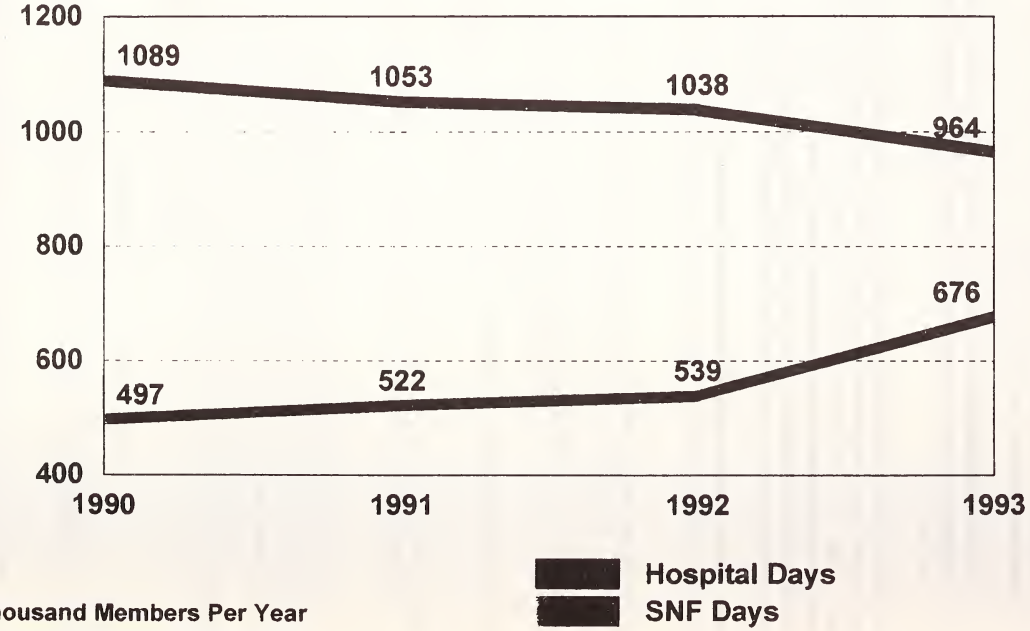
- support previous agency and Congressional efforts to place a moratorium on long term hospitals and determine why costs in such settings for identical care provided in SNFs is so much higher.

Mr. Chairman, thank you for holding this hearing. America's nursing facilities are capturing a greater share of Medicare patients for a reason - competition and innovation. We hope you will take notice of what the marketplace is doing and remove barriers to competition that remain in place in an antiquated and broken fee for services system. Most importantly, we urge you to adopt the industry PPS proposal and to work with our joint industry oversight group in refining the proposal for action by Congress next year and implementation no later than January 1, 1998.

Thank you Mr. Chairman. I'll be glad to answer any questions.

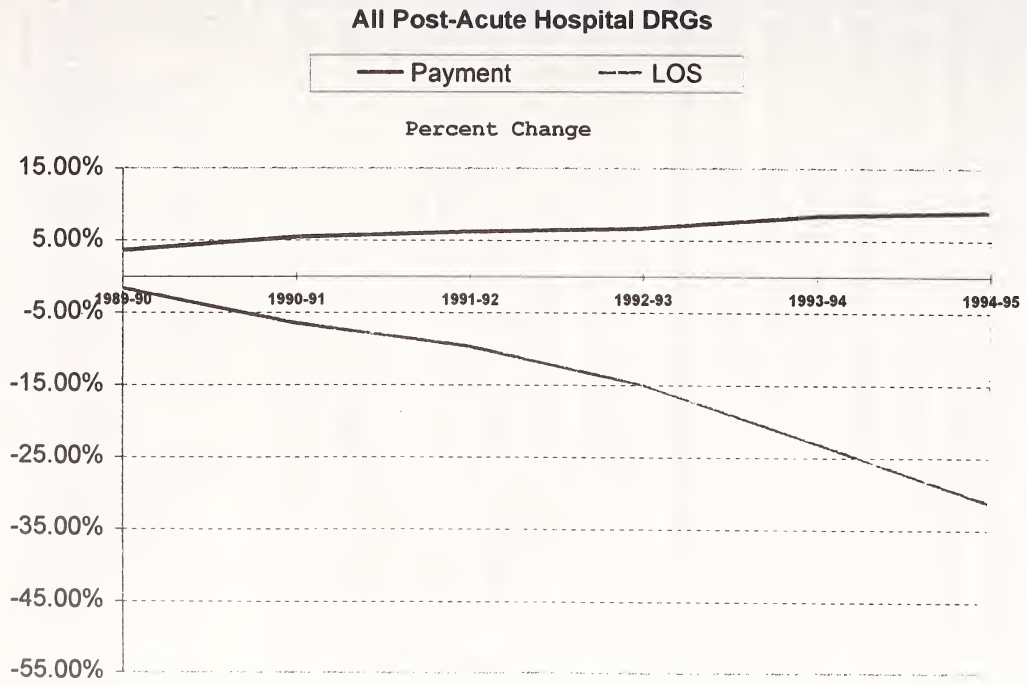
Quicker and Sicker

Utilization Trends 1990 - 1993 *



* Per Thousand Members Per Year
Data from PacifiCare of California

American Health Care Association



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Page 1

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American Health Care Association

Table 1

POST-ACUTE HOSPITAL DRGS				Annual Percentage Change													
				1989-90		1990-91		1991-92		1992-93		1993-94		1994-95		1989-95	
DRG	Description	Hospital Discharges 12/89	Hospital Discharges 12/95	Percent Treatable in Post-Acute	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT
1	Craniotomy age >17 except for trauma	26,393	32,723	no	-8.54%	7.45%	-8.20%	-3.80%	-8.44%	0.79%	-8.01%	-2.31%	-8.49%	-0.85%	-10.98%	1.21%	-50.66%	2.49%
12	Degenerative nervous system disorders	24,527	23,355	no	-2.99%	6.12%	-0.48%	0.72%	-3.39%	1.88%	-7.68%	3.59%	-7.40%	0.49%	-11.77%	2.52%	-33.71%	15.32%
14	Specific cerebrovascular disorders except TIA	326,880	351,205	no	-3.51%	4.30%	-3.07%	1.79%	-4.46%	0.30%	-6.28%	1.55%	-8.40%	0.69%	-9.27%	0.34%	-34.99%	8.97%
75	Major chest procedures	30,298	39,401	no	-1.70%	2.51%	-2.70%	3.07%	-4.31%	1.31%	-3.86%	2.80%	-6.00%	1.55%	-6.26%	1.69%	-24.83%	12.94%
76	Other respiratory system O.R. procedures w cc	31,437	38,785	no	0.01%	-0.51%	-3.27%	2.35%	1.03%	3.81%	-2.34%	2.38%	-5.70%	4.94%	-6.53%	2.63%	-16.81%	15.60%
79	Respiratory infections & inflammations age>17 w cc	103,828	207,606	no	-1.37%	-4.46%	-4.95%	0.06%	-1.93%	-1.21%	-5.10%	-0.07%	-6.92%	0.53%	-7.99%	-1.02%	-28.28%	-6.18%
85	Pleural effusion w cc	15,288	18,398	no	-1.25%	3.01%	-2.03%	2.83%	-2.09%	1.80%	-5.07%	4.51%	-5.52%	0.90%	-5.93%	1.17%	-21.89%	14.21%
88	Chronic obstructive pulmonary disease	93,088	345,365	no	-2.22%	-4.86%	-2.02%	0.37%	-1.08%	0.31%	-3.58%	1.65%	-6.18%	2.85%	-7.70%	1.04%	-22.73%	1.36%
89	Simple pneumonia & pleurisy age>17 w cc	332,396	415,072	no	-1.27%	-0.21%	-3.46%	0.65%	-1.96%	-1.24%	-4.40%	0.99%	-6.56%	0.39%	-6.51%	0.03%	-24.15%	0.60%
90	Simple pneumonia & pleurisy age>17 w/o cc	62,797	40,306	no	26.36%	-1.02%	-26.63%	-1.12%	-3.45%	-2.79%	-3.69%	-1.02%	-6.18%	0.13%	-4.72%	0.22%	-18.30%	-5.61%
96	Bronchitis & asthma age>17 w cc	208,655	60,887	no	-0.41%	0.87%	-2.52%	0.44%	-4.78%	-0.54%	-5.76%	0.71%	-7.20%	-4.87%	-8.29%	-2.14%	-26.96%	-5.52%
104	Cardiac valve procedure w cardiac cath	11,480	22,854	no	-2.74%	8.94%	-9.11%	5.06%	-3.55%	3.04%	-7.59%	-4.56%	-11.25%	0.30%	-9.20%	0.54%	-43.44%	13.32%
105	Cardiac valve procedure w/o cardiac cath	12,103	19,821	no	-3.61%	5.98%	-11.01%	3.52%	-2.92%	2.00%	-4.82%	-3.77%	-10.05%	1.04%	-8.87%	0.60%	-41.28%	9.36%
106	Coronary bypass w cardiac cath	62,031	90,165	no	-4.24%	7.06%	-2.64%	-2.03%	-3.20%	1.07%	-5.89%	5.60%	-8.20%	1.93%	-7.95%	0.99%	-32.12%	14.64%
107	Coronary bypass w/o cardiac cath	41,466	61,255	no	10.36%	5.44%	-14.89%	15.82%	-4.57%	4.23%	-5.20%	-13.23%	-8.28%	0.74%	-9.51%	1.11%	-32.08%	14.10%
113	Amputation for circ system disorders except upper limb & toe	33,301	45,003	no	5.91%	4.81%	-2.47%	9.09%	-1.80%	3.10%	-5.62%	4.92%	-8.70%	2.08%	-9.61%	0.58%	-22.49%	24.57%
121	Circulatory disorders w AMI & c.v. comp disch alive	139,310	158,928	no	-1.38%	3.04%	-4.06%	-0.69%	-4.16%	3.42%	-5.24%	1.06%	-7.93%	0.95%	-7.69%	1.21%	-30.46%	8.99%
126	Acute & subacute endocarditis	3,762	4,619	no	-1.11%	2.85%	-6.61%	0.99%	-5.28%	-1.65%	-5.72%	0.22%	-13.13%	-2.60%	-11.60%	2.76%	-43.46%	2.56%
127	Heart failure & shock	530,476	870,461	no	-1.29%	3.06%	-2.38%	0.89%	-2.26%	0.92%	-4.54%	2.47%	-6.74%	2.40%	-7.46%	1.23%	-24.68%	10.97%
128	Deep vein thrombophlebitis	31,570	19,612	no	-2.55%	2.16%	-1.65%	1.33%	-3.57%	-1.31%	-5.08%	1.23%	-6.22%	0.94%	-6.79%	1.12%	-25.66%	5.47%
130	Peripheral vascular disorders w cc	80,002	91,826	no	-0.23%	5.34%	-1.82%	2.74%	-3.50%	2.30%	-3.38%	1.53%	-5.46%	0.85%	-6.17%	2.89%	-20.57%	15.44%
148	Major small & large bowel procedures w cc	125,312	140,141	no	-3.06%	4.92%	-4.90%	-0.03%	-2.24%	0.02%	-3.76%	0.22%	-5.65%	2.75%	-4.87%	2.78%	-24.28%	10.65%
150	Peritoneal adhesiolysis w cc	17,887	22,516	no	-3.04%	2.90%	-0.95%	-2.82%	-3.61%	-0.34%	-3.68%	3.34%	-4.88%	1.64%	-4.73%	1.76%	-20.89%	6.48%
154	Stomach, esophageal & duodenal procedures age>17 w cc	48,511	35,661	no	9.78%	5.18%	-4.62%	-2.77%	-1.03%	15.66%	-3.32%	-1.40%	-6.78%	3.68%	-6.50%	2.16%	-12.47%	22.51%
170	Other digestive system O.R. procedures w cc	12,505	12,462	no	-1.11%	6.82%	-4.64%	-1.16%	-1.17%	2.15%	-4.80%	0.66%	-9.80%	2.36%	-6.20%	2.24%	-27.71%	12.86%
172	Digestive malignancy w cc	30,622	30,820	no	-2.39%	6.71%	-0.87%	4.10%	-2.28%	1.46%	-6.27%	5.23%	-7.91%	2.13%	-6.56%	0.61%	-26.29%	20.25%
195	Cholecystectomy w C.D.E. w cc	22,808	9,196	no	-3.48%	2.58%	-2.02%	0.66%	-0.75%	0.28%	-3.29%	4.63%	-5.46%	7.46%	-6.27%	3.32%	-21.25%	17.60%
197	Cholecystectomy except by laparoscope w/o C.D.E. w cc	60,303	28,016	no		2.81%		1.94%		-2.07%	22.65%	1.92%	-3.60%	20.57%	-4.57%	4.78%	14.28%	29.95%
199	Hepatobiliary diagnostic procedure for malignancy	3,424	2,205	no	1.27%	3.63%	-6.65%	4.82%	-3.55%	4.45%	-2.92%	-1.19%	-7.31%	2.35%	-10.31%	1.38%	-29.48%	15.44%
205	Disorders of liver except malig, cirr, alc hepa w cc	19,870	21,512	no	-1.39%	2.35%	-2.74%	1.48%	-1.23%	4.12%	-6.13%	0.40%	-6.17%	3.39%	-9.28%	-0.33%	-26.93%	11.43%
209	Major joint & limb reattachment procedures of lower extremity	206,383	328,015	no		3.32%	-6.32%	3.28%	-7.79%	1.07%	-9.93%	1.19%	-12.75%	0.72%	-12.95%	-0.19%	-49.75%	9.41%
210	Hip & femur procedures except major joint age>17 w cc	92,997	131,592	no	-5.90%	1.58%	-5.94%	-0.78%	-7.03%	-2.17%	-9.63%	0.04%	-10.58%	-0.44%	-12.37%	-0.31%	-51.44%	-2.08%
211	Hip & femur procedures except major joint age>17 w/o cc	45,414	25,325	no	-5.73%	0.27%	-7.30%	-0.69%	-8.20%	-3.28%	-8.08%	-1.59%	-10.91%	-0.55%	-11.80%	0.86%	-52.02%	-4.98%
213	Amputation for musculoskeletal system & conn tissue disorders	8,873	8,788	no	-3.36%	5.25%	-2.27%	1.38%	-2.36%	0.10%	-6.65%	2.91%	-9.31%	0.41%	-9.37%	-0.27%	-34.33%	9.78%
214	Back & neck procedures w cc	26,992	51,262	no	-10.56%	1.75%	-9.37%	-1.25%	-8.88%	-2.24%	-10.44%	1.32%	-12.06%	2.49%	-12.10%	3.22%	-63.40%	5.28%
217	Wnd debrid & skin grft except hand, for musculoskel & conn tissue dis	14,593	19,341	no	-2.88%	7.34%	-3.97%	3.96%	-2.88%	2.13%	-6.99%	-1.88%	-10.57%	1.43%	-9.90%	-0.41%	-37.20%	12.79%
235	Fractures of femur	6,500	5,543	no	-6.77%	3.70%	-9.22%	0.49%	-7.64%	-2.99%	-13.03%	-5.43%	-14.64%	-3.20%	-12.34%	-5.79%	-63.64%	-12.22%
236	Fractures of hip & pelvis	39,756	37,803	no	-4.10%	1.45%	-5.14%	1.60%	-7.25%	-0.42%	-5.41%	-1.96%	-10.72%	-1.01%	-9.92%	-0.74%	-42.55%	-1.08%
238	Osteomyelitis	5,436	7,538	no	1.49%	0.43%	-2.68%	1.56%	-6.66%	1.92%	-1.94%	-1.21%	-10.92%	-0.76%	-11.21%	0.22%	-32.12%	2.16%
239	Pathological fractures & musculoskeletal & conn tissue malignancy	58,606	59,581	no	-0.27%	5.65%	-2.71%	4.18%	-3.18%	2.97%	-5.21%	3.10%	-8.87%	1.30%	-9.17%	0.69%	-29.45%	17.69%
243	Medical back problems	132,108	79,979	no	-1.22%	4.10%	-0.02%	3.43%	-1.15%	2.03%	-3.46%	4.13%	-5.89%	4.19%	-8.51%	2.78%	-20.25%	20.66%
254	Fx spm stm & dist of uparm lowleg ex foot age>17 w/o cc	16,940	9,205	no	-1.73%	3.15%	-5.30%	1.17%	-3.33%	-0.90%	-3.44%	1.49%	-9.17%	2.54%	-3.63%	2.41%	-26.59%	9.88%
263	Skin grft &/or debrid for skin ulcer or cellulitis w cc	29,386	29,088	no	-4.87%	3.78%	-7.65%	8.24%	-4.59%	-2.58%	-7.89%	-3.88%	-11.61%	-2.21%	-11.86%	-2.63%	-48.29%	-1.28%
264	Skin grft &/or debrid for skin ulcer or cellulitis w/o cc	7,628	3,559	no	-6.64%	-6.09%	-5.10%	-2.33%	-3.23%	-3.73%	-11.01%	-0.85%	-7.30%	-0.97%	-7.92%	-4.42%	-41.20%	-18.39%
271	Skin ulcers	17,177	21,515	no	-2.03%	1.89%	-6.97%	8.78%	-3.95%	-0.08%	-6.53%	-2.50%	-8.85%	-0.03%	-9.68%	-2.60%	-37.81%	5.45%
277	Cellulitis age>17 w cc	56,893	79,054	no	-2.30%	2.52%	-2.82%	0.85%	-3.21%	-0.15%	-4.43%	-0.13%	-7.14%	0.22%	-7.55%	-0.10%	-27.46%	3.21%
278	Cellulitis age>17 w/o cc	27,739	26,008	no	-1.61%	-0.14%	-3.86%	1.18%	-2.90%	-1.76%	-5.67%	-1.48%	-6.80%	-0.37%	-5.29%	1.56%	-23.13%	-3.35%
285	Amputat of lower limb for endocrine, nutrit. & metabol disorders	3,717	4,886	no	-2.68%	2.21%	-1.06%	0.85%	-9.96%	-1.59%	-5.24%	2.81%	-12.95%	-5.39%	-12.07%	-0.27%	-43.96%	-5.79%
287	Skin grafts & wound debrid for endoc, nutrit & metab disorders	7,836	6,284	no	0.04%	5.86%	-6.93%	1.91%	-1.47%	1.62%	-9.88%	-1.90%	-6.68%	2.42%	-13.64%	-2.94%	-38.57%	6.97%
294	Diabetes age>35	100,709	86,024	no	-1.35%	3.97%	-3.24%	2.51%	-2.63%	0.40%	-4.81%	1.32%	-8.59%	1.22%	-7.78%	1.14%	-28.40%	10.56%
296	Nutritional & misc metabolic disorders age>17 w cc	187,031	218,940	no	-2.34%	5.14%	-2.20%	2.00%	-3.69%	0.53%	-5.54%	2.01%	-9.28%	-0.28%	-9.28%	-0.28%	-30.45%	9.91%
320	Kidney & urinary tract infections age>17 w cc	143,597	169,078	no	-1.42%	3.38%	-2.79%	0.13%	-3.02%	0.09%	-6.40%	-0.32%	-7.50%	0.21%	-8.50%	-1.18%	-29.64%	2.31%
331	Other kidney & urinary tract diagnoses age>17 w cc	26,730	38,181	no	-0.93%	9.16%	-1.63%	2.10%	-1.78%	1.40%	-2.75%	3.77%	-5.29%	2.23%	-8.55%	2.35%	-20.93%	21.01%
403	Lymphoma & non-acute leukemia w cc	24,880	34,812	no	-2.50%	6.51%	-0.33%	2.03%	-5.23%	1.29%	-4.63%	6.08%	-7.87%	1.14%	-6.25%	2.38%	-26.82%	19.43%
410	Chemotherapy w/o acute leukemia as secondary diagnosis	135,537	85,872	no		6.77%	0.35%	7.05%	0.80%	8.81%	-6.05%	11.84%	-2.47%	11.29%	0.30%	2.24%	-7.07%	48.02%
413	Other myeloprolf dis or poorly dff neopl diag w cc	10,418	8,421	no	-2.72%	8.78%	-3.16%	3.93%	-0.36%	2.36%	-6.71%	1.93%	-8.13%	5.48%	-9.11%	-0.88%	-30.20%	21.81%
418	Septicemia age>17	106,864	192,133	no	-0.97%	1.41%	-2.56%	2.01%	-2.93%	0.54%	-4.72%	1.09%	-7.46%	1.02%	-7.20%	-0.25%	-25.85%	5.83%
439	Skin grafts for injuries	1,242	867	no	-12.04%	2.48%	-16.47%	1.93%	12.35%	-7.95%	-9.81%	-19.26%	-3.18%	16.02%	-3.15%	-2.90%	-32.30%	-9.87%
462	Rehabilitation	8,358	9,360	no	-1.06%	10.64%	-3.21%	-1.10%	-5.27%	0.14%	-1.92%	-1.34%	-9.70%	-1.86%	-7.57%	-2.24%	-28.73%	4.23%
468	Extensive O.R. procedure unrelated to principal diagnosis	70,101	58,649	no	-0.75%	5.38%	-6.21%	5.26%	1.01%	0.89%	-3.46%	1.53%	-8.20%	3.48%	-6.36%	3.87%	-23.97%	20.42%
471	Bilateral or multiple major joint procs of lower extremity	5,027	9,111	no	-4.76%	0.41%	-10.37%	1.72%	-9.85%	0.96%	-11.09%	0.00%	-15.06%	0.71%	-16.24%	-1.84%	-67.17%	1.97%
475	Respiratory system diagnosis with ventilator support	87,755	89,514	no	1.52%	21.26%	-4.32%	-0.06%	3.60%	2.33%	-3.34%	1.30%	-5.79%	4.98%	-5.83%	0.72%	-14.17%	30.52%
	Total Average for All Post-Acute DRGs	**4,229,555**	**4,999,533**		**-1.55%**	**3.85%**	**-4.84%**	**1.81%**	**-3.21%**	**0.79%**	**-5.24%**	**0.48%**	**-8.09%**	**1.78%**	**-8.30%**	**0.53%**	**-31.03%**	**8.99%**

Sources: 1) U.S. Federal Register Final Rule September 1, 1989-1995. 2) U.S. Federal Register Proposed Rule May 31, 1989-1995. 3) ProPAC Report and Recommendations to Congress, March 1, 1989-1996

Chairman THOMAS. Thank you very much, Ms. Bailis.
Mr. McMeekin.

STATEMENT OF JOHN C. McMEEKIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CROZER-KEYSTONE HEALTH SYSTEM, MEDIA, PENNSYLVANIA; ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. MCMEEKIN. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman, and Members of the Subcommittee on Health, I am John McMeekin, president and chief executive officer of the Crozer-Keystone Health System. I am here today representing the American Hospital Association and our 5,000 members, all concerned with the matters you are discussing.

Crozer-Keystone Health System is a nonprofit, integrated health system that provides a broad range of services to many of the residents living in Delaware County, a population of 550,000 and in many of the surrounding Philadelphia communities. Our system includes 100 employed primary care physicians, three community hospitals, a very large tertiary teaching hospital and six long-term care facilities.

Four of the long-term care facilities are freestanding, with a total of 800 skilled nursing beds; 2 are hospital-based with a total of 51 skilled nursing beds.

As the 24-hour-a-day, 7-day-a-week community health resource, a hospital brings together a broad array of services and practitioners to provide comprehensive care for its community. Because Medicare is the largest payer for health services, payment policies being considered by this Subcommittee are of critical interest to us and our colleagues across the country. Hospitals and health systems supported adoption of Medicare's in-patient prospective payment system and we believe that a properly structured prospective payment system for skilled nursing facilities and home health services is a move in the right direction.

To make that move a more successful one, we strongly recommend that prospective payment for home health and skilled nursing reflect the following key criteria.

One, they must recognize the variations in cost that result from the different nursing and rehabilitative needs of individual patients.

Two, payments must be adjusted to recognize the geographical differences that are beyond the control of any health care system.

Three, the new system should incorporate administrative and general service costs that government mandated accounting rules can add to a skilled nursing unit. This is particularly true of a hospital-based unit that has to bear both the regulatory burden as a hospital and, as well, as a hospital-based skilled nursing facility.

The new payment system should provide clear public recognition of the uncompensated care mission that hospitals fulfill in our Nation. Different than freestanding facilities, the hospital-based skilled nursing facility, because it is a part of the hospital, is less able to pick and choose which patients it cares for. Those who present themselves in our emergency rooms are cared for regardless of their ability to pay. That's part of our mission and part of

your regulations. Many of those patients end up in our skilled nursing facilities.

Finally, the new system should recognize the higher costs of hospital-based services. These costs are the result of a hospital's ability to perform many services at any time, it's greater availability of laboratory and x ray services, and again, the requirements imposed by accreditation.

The intensity of care provided in a hospital-based skilled nursing facility is significantly higher than that provided in a freestanding facility. This is due to most patients coming from the acute stay. I would differ from those who have testified to the contrary, there is little evidence that I could present to this Subcommittee to support the fact that care is equal across the freestanding and the hospital-based skilled nursing facilities. Our own experience is that the more acutely ill patients are in the hospital-based facility, and that's where the physicians feel most comfortable in transferring their patients.

In my health system, physicians are very careful to discharge patients to the proper care setting. As a result, some patients are discharged to the higher intensity hospital-based units, while others are moved and more appropriately discharged to our freestanding facilities.

There are considerable differences in the cost of providing higher intensity rather than lower intensity services. Our 4 freestanding skilled nursing facilities average 200 beds, compared to 24, on average, in our hospital-based units. This allows us to spread our costs over a larger economic unit and also to get more balance in the patient mix.

In conclusion, Mr. Chairman, it is important to remember that while great changes are occurring in the health care delivery system, hospitals still have one foot deeply rooted in fee-for-service. Crozer-Keystone, for example, is making a strong move toward being a fully-integrated delivery system. As a result, we consider a new prospective payment system for home health and skilled nursing services to be a transition on our way to full capitation.

However, fee-for-service is still a big part of health care, especially for America's seniors. It is clear that changes being considered by this Subcommittee will have a deep and immediate effect on our ability, as hospitals and health systems, to serve our community. As you deliberate new payment policies for home health and skilled nursing facilities, it is important to keep in mind the unique characteristics of hospitals and the bigger changes occurring in our field.

We look forward to working with you and your Subcommittee on developing policies that enhance the ability of hospitals and health systems to serve our communities.

Thank you.

[The prepared statement follows:]

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the U.S. House of Representatives
on
Medicare Payment Policies
for
Home Health Agency and Skilled Nursing Facility Services

July 23, 1996

Mr. Chairman, I am John C. McMeekin, president and CEO of Crozer-Keystone Health System. I am pleased to testify on behalf of the American Hospital Association (AHA) and its 5,000 members -- hospitals, health systems, networks and other providers of care -- on Medicare payment for home health agency and skilled nursing facility services.

Crozer-Keystone Health System is a not-for-profit, integrated health system that provides a broad continuum of care to 550,000 people in Delaware County and surrounding communities. Our system includes 100 employed primary care physicians, three community hospitals, one tertiary medical center and six long-term care facilities. Four of these long-term care facilities are freestanding, with a total of 800 skilled nursing beds; two are hospital-based, with a total of 51 skilled nursing beds.

BACKGROUND

While the traditional hospital historically provided acute inpatient care, emergency room, and limited outpatient services, the contemporary hospital offers its community a much broader array of services. Today, hospitals and integrated health care networks provide:

- routine and intensive inpatient care
- comprehensive ambulatory services, including ambulatory surgery
- sub- and post-acute services
- skilled nursing care
- community-based health and mental health centers
- home and community health services
- hospice care
- and, for many, an array of community-based physician primary care services

As the 24-hour-a-day, seven-day-a-week community health resource, hospitals increasingly bring together a broad array of services and practitioners to provide comprehensive care for their communities. Payment policies being considered by this subcommittee are of critical interest to us and our colleagues across the country, and will assist hospitals and health systems as they develop integrated delivery systems.

Because Medicare is the largest payer for health service, its policies have an impact far beyond the monies spent. They set the social benchmark for other payers--private and public. Thus, my testimony today will focus on the following points as you examine policies for paying home health and skilled nursing services.

America's hospitals and health systems believe that Medicare payment policies should:

- Clearly recognize the variation in costs that results from the different nursing and rehabilitative needs presented by individual patients.

- Adjust payments to recognize geographic differences in costs that are beyond the control of the health care system.

- Recognize the higher costs of hospital-based services, costs that result from a hospital's ability to perform a number of different services at any time; its greater availability of laboratory and x-ray services; and requirements imposed on the hospital by accreditation.

- Incorporate legitimate administrative and general service costs of the hospital or health system that are added to a skilled nursing unit as a result of government-mandated accounting rules.

- Provide clear public recognition of the uncompensated care mission that hospitals fulfill in our nation.

HOSPITALS SUPPORT AN IMPROVED PAYMENT SYSTEM

The AHA has been and remains a proponent of improved payment arrangements that promote cost-effective utilization of appropriate patient care services. In the early 1980s, despite limitations in some of the technical features and implementation steps, the AHA supported adoption of Medicare's hospital inpatient prospective payment system (PPS).

For almost a decade, the AHA has consistently called for a comprehensive, easy-to-administer prospective payment system for hospital ambulatory services. Similarly, hospitals and health systems believe a properly structured prospective payment system for skilled nursing facility and home health services is a move in the right direction. Beyond prospective payment, the AHA has been an advocate for more than five years for a capitation-based payment system that aligns the incentives of purchasers, providers, and practitioners, and encourages improved efficiency in the health care system.

The AHA has also supported new organizational arrangements that would facilitate the use of new methods of payment for health services. For example, the AHA is sponsoring, through a major grant from the Kellogg Foundation, a demonstration project to create Community Care Networks that provide a comprehensive range of ambulatory, inpatient, and community-based services. For two years, the AHA has encouraged legislation to develop Provider Sponsored Organizations (PSOs), which would provide a means for highly integrated, at-risk health delivery systems developed by providers and practitioners to contract directly with Medicare for the care of beneficiaries.

And Crozer-Keystone is proud to have been chosen by the Health Care Financing Administration to participate in its Medicare Choices demonstration program. Our goal is to demonstrate that we can build on our existing relationship with our senior community to overcome their concerns about managed care, and to focus on keeping them healthy while providing superior service when they get sick. Medicare's payment policies are critical to our success.

KEY CRITERIA FOR A NEW PAYMENT SYSTEM

Hospitals and health systems strongly recommend that Medicare's home health and skilled nursing facility services payment policies reflect these key criteria.

- **Medicare should recognize, at a minimum, differences in levels of physical functioning, cognitive capabilities and behavior of the patient, and intensity of rehabilitation and therapy services.** A clear variation in costs results from the different nursing and rehabilitation needs of each patient. Hospitals discharge patients

to different skilled nursing facilities that have different capabilities. Some provide more intensive nursing and therapy; some admit more severely ill or more disruptive patients; some are more capable of responding to medical episodes. These differences need to be recognized in the payment. Otherwise, low intensity nursing facilities would receive a windfall and high intensity facilities would be penalized.

For example, within my own health system physicians are careful to discharge patients to a setting that offers the necessary intensity of services and therapies. As a result, some patients are discharged to our higher-intensity, hospital-based skilled nursing units, while others are more appropriately discharged to our lower-intensity, lower-cost, freestanding skilled nursing facilities.

These differences in patients' needs and costs are known as "case mix" costs. They are recognized in the Medicare hospital inpatient PPS system through a combination of the Diagnosis-Related Groups (DRG) classification system, supplemental payments for outlier cases, and other payment add-ons for the higher costs associated with indirect medical education and treating large numbers of low-income individuals. While the hospital inpatient PPS system is inappropriate for long-term care and home care patients, the underlying principle of recognizing certain patient-related cost differences is the same.

- **Medicare should recognize geographic differences in costs, which are beyond the control of the health care system.** Providers serve Medicare patients in communities with different costs of delivering care. Some communities have higher wage rates than others; some have higher supply or operational costs than others. While PPS and the Resource-Based Relative Value Scale (RBRVS) revealed the difficulty of drawing geographic boundaries for payment purposes, the difficulties are minor compared to the inequities that would result from failing to recognize geographic cost differences.

- **Medicare should recognize the added operational costs associated with hospital-based skilled nursing services.** Hospital-based services are provided by delivery systems that have a broad array of services and responsibilities. As a result, additional costs result from: a hospital's ability to provide services on demand (often referred to as "standby" services) that are not available from limited service providers; greater availability of laboratory and x-ray services that support hospital-based as well as freestanding providers; and requirements imposed on the hospital by licensure and accreditation.

- **Medicare should incorporate accounting costs that result from government-mandated cost-finding practices, which historically over-allocated hospital overhead from inpatient care units to ambulatory, community-based, and nursing home units. Or, Medicare should increase inpatient PPS payments to adjust for prior accounting requirements.** Under Medicare's original policies, services provided under Medicare Part A were reimbursed on a cost basis using accounting procedures prescribed by Medicare. While there were many concerns with these procedures, they were equitable because they applied to all Medicare Part A services. Because Medicare accounting procedures require allocation of all general service and administrative costs among the various Part A facilities and units, any over-allocation of costs in one area would result in under-allocation in another.

  When Medicare hospital inpatient PPS was established, it based inpatient payments on the level of costs determined using the accounting practices that had been used for cost-based reimbursement. Nevertheless, equity was preserved in part by continuing to recognize the consequences of Medicare's accounting requirements through the payment differential for hospital-based facilities and services.

- **Medicare payments should provide clear public recognition of the uncompensated care missions that hospitals and hospital-based services fulfill in our nation.**

Hospitals, by legislation (Emergency Medical Treatment and Active Labor Act -- EMTALA) and commitment to community service, provide emergency services that evaluate and treat all individuals regardless of ability to pay. Once admitted and treated, the patient may be reassigned to a hospital-based home health or nursing home service that is medically appropriate and lower in cost than an inpatient unit.

However, the uncompensated care patient brings no revenue, regardless of where the patient receives care. Unlike freestanding home health agencies and nursing home facilities that have no emergency room entrance for uninsured or underinsured individuals, the hospital-based facility bears a disproportionate share of the costs of uncompensated care.

CONCLUSION

Taking these issues into consideration, it is clear that changes being considered by the subcommittee will have a deep and immediate effect on the ability of hospitals and health systems to serve their communities. As you deliberate new payment policies for home health agency and skilled nursing facility services, it is important to keep in mind the unique characteristics of hospitals, and the important role they play in their communities. We look forward to working with you in ensuring that new payment policies enhance, not hinder, our ability to serve our communities.

Chairman THOMAS. Thank you, Mr. McMeekin.
Mr. Lane.

STATEMENT OF LAURENCE F. LANE, PRESIDENT, NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG-TERM CARE

Mr. LANE. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman, and Members of the Committee.

My name is Larry Lane and I am president of the National Association for the Support of Long-Term Care. NASL was founded in 1989 and it is the only national organization that concentrates exclusively on legislative and regulatory matters regarding the professional services and supplies provided to beneficiaries in a skilled nursing setting.

I ask for permission to submit the materials with my statement and also to submit, for the record, a statement from the Post-Acute Coalition.

[The statement from the Post-Acute Coalition was not available at the time of printing.]

Chairman THOMAS. Without objection.

Mr. LANE. I have been asked by the Subcommittee to focus my comments on part A and part B ancillary services in contracting relationships. As the data that I submitted to the Subcommittee underscores, the growth of ancillary services reflects the changing roles, case mix both intended and unintended in the skilled nursing setting.

Facilities have three options in providing ancillary services to skilled nursing patients. One, hire staff and develop services; two, enter into an under-arrangement contract with a supplier or provider and bill for the services through the facility; or, three, enter into an under-agreement contract with a supplier or provider and let the supplier or provider bill the program for the services.

This contracting authority permits SNFs to purchase ancillary services for residents only when they are medically necessary and without incurring excess overhead or excess capacity.

The decision to secure products or services either under arrangement or under agreement depend upon demand, focus and availability. From a facilities standpoint, the current cost-based reimbursement system provides an incentive to either hire staff or secure services or products under arrangement. Medicare pays the lower of reasonable costs or charges.

Whatever approach is taken by the facility, the facility still has the responsibility for the clinical management and for the care and services provided in the facility. Let me make it very clear that the way that ancillary services are billed under Medicare is confusing and should be changed.

As an example, just reading a skilled nursing handbook transmittal 341 that just came out, it is clear that even HCFA is struggling in offering guidance on billing and coding instructions. The present system is illogical and it should be changed. Any reform of post-acute services part A should be billed for part A services and part B should be billed for part B services.

In calculating what part A reimbursement should be, there is a need to make appropriate adjustments to compensate for services currently billed under part B.

We do not have the data nor do nursing facilities have the experience to justify applying these consolidated billing principles immediately to part B services that are provided after part A eligibility is exhausted.

The issues that we are discussing today are the logical and foreseeable result of policy decisions made to improve access and beneficiary services. Statute and regulations have not kept pace with changes in the care system and, in some instances, act as barriers in providing low-cost, high-quality services.

There are conflicting rules and outdated provisions. We urge the Congress to replace the cost-based reimbursement for part A benefit. We need to develop a prospective payment system for the part A benefit that one, recognizes legitimate differences in factors that affect cost; two, encourages appropriate access to care for Medicare beneficiaries; three, encourages the provision of high-quality care; and four, provides incentives for efficient use of resources.

A system which is designed solely to secure cost savings will not achieve these goals. The development of a prospective payment system must reflect patient need and the accuracy of the data used to identify patient need in constructing the prospective payment system is crucial. It must include appropriate patient assessment tools that accurately reflect all that is involved in patient care.

There is a need to encourage quality outcomes, offer ease of administration and establish reasonable payment levels. At the same time, it is important to establish objectives that can be implemented in a realistic timeframe.

Let me conclude by making these specific recommendations. First, consolidate the part A and part B billing during the part A stay. Second, do not consolidate billing for part B services after the exhaustion of the part A benefit, or when part A is not being billed. Third, address the complexities caused by current law, eliminate hospital transfer requirements for such services as respiratory therapy, x ray, and lab. Fourth, implement a part A SNF prospective payment system which reflects patient need and facility-specific variation.

I appreciate this opportunity to submit information and I look forward to working with the Subcommittee.

[The prepared statement follows:]

STATEMENT OF LAURENCE F. LANE, PRESIDENT
THE NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

Mr. Chairman:

Good afternoon Mr. Chairman and Members of the Committee. My name is Larry Lane, and I am President of the National Association for the Support of Long Term Care. NASL was founded in 1989 and is the only national organization that concentrates exclusively on legislative and regulatory matters regarding the professional services and supplies provided to beneficiaries in a skilled nursing facility.

We have been asked by the staff to comment on the following five areas:

- Explain the reasons for growth of SNF ancillary services;
- Clarify relationships of Part A and Part B ancillary services;
- Overview contractual arrangements between facilities, suppliers and providers;
- Clarify reimbursement for SNF therapy services; and
- Offer our recommendations for policy changes.

In short, NASL supports:

1) Reforms that require billing Part A for Part A services;
2) Elimination of artificial legal barriers to services for nursing home residents, such as transfer agreements and three day stay requirements; and
3) Transitioning to a PPS system under Part A for skilled nursing services.

With your permission, I will summarize the key points and request the text and accompanying materials be submitted as part of the hearing record.

GROWTH OF ANCILLARY SERVICES

The growth of ancillary services reflect the changing role and case-mix, both intended and unintended, of skilled nursing facilities. Moving patients out of hospitals into more cost-effective and appropriate settings was one of the goals of hospital prospective payment reform enacted in 1983. This has been a substantial success with clear benefits for both the Medicare program and for Medicare beneficiaries. Due to this success, the patient demographics of SNFs have changed. SNFs are now admitting higher acuity patients who require more services than the typical SNF resident of 10 years ago. The type of health care delivered within the SNF has changed.

Over the past 10 years, the nursing home sector assumed greater responsibility for post acute medical services, and the changes can be summarized as follows:

- **Higher patient acuity** often caused by hospital discharging patients "sicker and quicker;"

- **Regulatory mandates** such as OBRA 87 which required facilities to help residents achieve "the highest practicable level of functioning" and

- **Increased Medicare utilization** in both the number of SNF beds and the number of patients.

With few exceptions, nursing facilities meet the needs of two significantly different populations: a short-stay patient requiring intense medical and professional support, and a long-stay resident requiring intermittent medical management. Congress should evaluate whether any changes made adversely effect either type of patient.

As we look at ways to reform SNF reimbursement, we must design a system that recognizes the significant differences in patient acuity and case-mix, and we must retain the incentives to move patients into a more cost-effective and appropriate settings.

PART A/PART B AND CONTRACTING RELATIONSHIPS:

Facilities have three options in providing ancillary services to SNF patients: 1) hire staff to deliver the service, 2) enter into an "under arrangement" contract with a supplier or provider and bill for the services through the facility; or 3) enter into an "under agreement" contract with a supplier or provider and let the supplier or provider bill the program for the services.

While nearly 13,000 nursing facilities participate in the Medicare program, fewer than 2,000 facilities account for 50% of Medicare reimbursed days of care and less than 5,000 facilities account for 90% of the Medicare reimbursed days of care. Facilities admitting more than 10-20 new admissions per month may sustain a patient flow sufficient to justify a broad array of medical professional services. However, most facilities experience a significantly lower turn-over of resident and, therefore, offer a more narrow scope of core services. These facilities, under arrangement or under agreement, deliver specialized services on an as-needed basis.

Diverse patient needs drive program development. Most facilities, especially those with a small number of admissions/discharges per month, have strengthened professional medical services and supplies and specialty programs through contractual relations.

The demand for professional medical services is based upon patient need. Unless a facility has a relatively high volume of admission and discharges, demand will fluctuate. Where there is fluctuating demand for ancillary services, it is often less costly to contact with an outside provider or supplier. Even for higher volume ancillary services, such as therapy services, market studies have affirmed lower per unit cost of delivery in contracting relationships. There are savings to Medicare when services are purchased only when they are needed.

The decision to secure products or services either under arrangement and/or under agreement depends upon demand, focus, and availability. From a facility standpoint, the current cost-based reimbursement system provides an incentive to hire staff or secure services or products under arrangement. Medicare pays the lower of reasonable costs or charges. Whatever approach used by the facility, the facility still has the responsibility for the clinical management and for the care and services provided in the facility.

The way ancillary services are billed under Medicare is confusing and should be changed. Services are billed under Part B during a Part A stay not because of patient care needs but simply because HCFA often requires it. It is clear from reading the recent SNF Handbook Transmittal 341 (November 1, 1995) that even the agency is struggling to offer guidance on billing and coding instructions.

The present system is illogical, and it should be changed. In any reform of post-acute services, Part A should be billed for Part A services and Part B should be billed for Part B services. In calculating what Part A reimbursement should be, there is need to make appropriate adjustments to compensate for services currently billed under Part B. This is essential to ensure that future Part A reimbursement will accurately reflect how post-acute care services and products are presently being delivered. We do not have the data nor do many SNFs have the experience to justify applying these consolidated billing principles immediately to part B services that are provided after Part A eligibility is exhausted.

THERAPY REIMBURSEMENT

As stated above, facilities have options in securing therapy services. Services can be provided by facility staff, under arrangement with a therapy company, under agreement with a rehabilitation agency and/or under agreement with an independent therapist. Under existing rules, each therapy is individually recognized, and therefore, the facility can receive different therapies in a different manner.

When services are provided "under arrangement," the Medicare statute gives the Secretary authority to establish "salary equivalency guidelines" as limits for evaluating reasonable costs. Guidelines have been promulgated only for physical therapy and respiratory therapy. It is our understanding that HCFA is recalculating these guidelines and promulgating new guidelines for occupational therapy and speech language pathology services.

Members of NASL have been working closely, and cooperatively, with HCFA in developing these new rules.

MEDICARE POLICY RECOMMENDATIONS:

Our recommendations are the logical and foreseeable result of policy decisions made to improve access and beneficiary services. A decade ago, we were debating how to reduce unnecessary hospital stays and improve the quality of nursing home services. The increased utilization of post-acute services is proof that patients are receiving services in more appropriate settings.

Statutes and regulations have not kept pace with market changes, and in some instances act as barriers in providing low cost, high quality services. There are conflicting rules and outdated provisions.

We urge the Congress to replace the cost based reimbursement for the Part A benefit. A number of technical changes clarifying the existing Part A benefit can be done through regulation, but some may need Congressional action.

We need to develop a prospective payment system for the Part A benefit that 1) recognizes legitimate differences in factors that affect cost, 2) encourages appropriate access to care for Medicare beneficiaries, 3) encourages the provision of high quality care, and 4) provides incentives for efficient use of resources. A system which is designed solely to secure cost savings will not achieve these goals.

The development of a prospective payment system must reflect patient need. The patient must come first. The accuracy of the data used to identify patient needs in constructing the PPS system is crucial. It must include a patient assessment tool that accurately reflects all that is involved in patient care. It should also encourage quality outcomes, offer ease of administration, and establish reasonable payment levels. It is important to establish objectives that can be implemented in a realistic time frame.

Bundling the payment into the hospital DRG would greatly disrupt the delivery of patient care and reverse the incentives to move patients into the most cost-effective setting. DRGs should probably be recalibrated to reflect changes in the health care marketplace and medical innovations that would provide substantial savings to Medicare. It is noteworthy that in the private sector, most payers do not premise payment for post-acute care on hospital reimbursement. Private payers are aware that diagnosis is not a good predictor of post acute services, that the hospital payment is based on the highest cost model, and that hospitals may not be best suited to deliver post-acute care.

With regard to skilled nursing facilities, the HCFA sponsored case-mix demonstration project is focused on a limited number of facilities. While this information is critical in developing a national PPS system, it may not be reflective of all types of SNF patients and the Committee should evaluate what additional data should be collected. The implementation of a national program might require a first step that focuses on facility-specific variations. It may be unrealistic to expect an all-inclusive payment system in place within twelve months; however, it may be realistic to work from the existing routine cost limits and add specific dates for incorporating ancillary services. The base years used to establish the prospective payment system and the manner in which those measures are updated and trended forward are critical. A phased implementation period would facilitate a smooth transition. Timely, accurate and relevant data is essential.

Safeguards should be written to require that services reach beneficiaries, that suppliers and providers will receive timely payment and that quality will be maintained. A realistic SNF prospective payment system for Part A services will focus attention on the need for consolidated reporting and coding of services for Part A patients across care settings. Such information will help in evaluating the appropriateness of services. Usable, uniformed measures for clinical outcomes should be developed as the current system relies too heavily on factors which add costs, but do not necessarily ensure meaningful results.

Likewise, any prospective payment system must enable the dynamic health care market to continue to progress and not lock-in the status-quo. The reimbursement system should encourage medical and therapeutic innovation and permit services to evolve to meet changing patient needs.

To begin implementation of this system, let me conclude by making these specific recommendations:

First: Consolidate the Part A and Part B billings during the Part A stay. This permits the collection of data crucial in developing an appropriate prospective payment system and the obligation of the SNF to reimburse the ancillary provider would not be affected.

Second: There should not be consolidated billing for Part B services after the exhaustion of the Part A benefit or when there is not Part A billing.

Third: Address the complexities caused by current law. Eliminate hospital transfer requirements for such services as respiratory therapy, X-ray and labs. These requirements increase Medicare expenditures by locking in higher cost and non-competitive providers.

CONCLUSION:

Two decades ago there was an article in the Milbank Journal on nursing homes as the "after thought" industry. The fact that this hearing is focused on the services we provide is recognition that we have evolved into essential care providers.

We appreciate this opportunity to clarify trends, comment on delivery and offer suggestions for future policy changes, and urge your support of our recommendations.

I will be pleased to answer questions on any of the points I have made in this testimony or respond to any issues that may have been raised earlier. NASL shares this Committee's goal of ensuring that every Medicare dollar buys affordable, quality health care for the patient. We pledge to work with you to reach this goal.

Mr. CHRISTENSEN [presiding]. Thank you.

I would like to thank the panel also for being here all afternoon and waiting to testify. I appreciate your patience. Ms. Bailis, I wanted to go over a question that came up earlier today while Mr. Newhouse and Dr. Young were testifying.

They said in their written statement that no information exists or prospective payment system do not indicate strong association between the changes in length of stay and increases in SNF service use. Thus, we do not believe the increased use in the nineties is much related to change patterns in, in-patient use.

Looking at your chart there, it appears to me that there is some data out there that reflects that SNFs have been able to make a real positive effect on this. Would you elaborate on that?

Ms. BAILIS. Yes. I am familiar with the ProPAC data related to length of stay and, in fact, when you look at the initiation of DRGs in 1983, you can see a gradual diminution of the length of stay. If one looks only at that factor, hidden in there is no information that would lead to the conclusion that I came to. But, I suggest to you that it's more complex than that. That when you pull out DRGs, specifically those which generate post-acute care or subacute care—hip replacements, strokes, certain diagnoses that tend to lead to or require the use of post-acute care—when you look specifically at those DRGs and pull out that data related to length of stay, you see a real indication of decline in the DRG with the escalation of subacute care, which is to say that subacute care fueled the decreased utilization of the hospital DRG or the acute stay.

Mr. CHRISTENSEN. Looking at the ancillary services that you provided, you are the chief operating officer of the ADS Group, and how many facilities do you operate?

Ms. BAILIS. Sixty.

Mr. CHRISTENSEN. And over the last 5 years, have the ancillary services provided in all of your operations continued to increase?

Ms. BAILIS. My operations include freestanding SNFs, freestanding subacute units, and hospital-based skilled nursing facilities and assisted living facilities.

The assisted living facilities do not particularly make use of ancillaries. In all the other facilities there has been a significant increase in ancillary utilization over the last 5 years.

And it is my belief, by the way, that an episodic prospective payment system akin to the kinds of payment systems that managed care, Medicare risk programs are using would help the control that, quite frankly, is necessary because the incentives are not there to control ancillary utilization currently in our payment system.

Mr. CHRISTENSEN. Mr. McMeekin, would you answer the question that I asked her about the statement by Mr. Newhouse?

Mr. MCMEEKIN. I would be happy to, Mr. Christensen.

First of all, let me just amplify on Ms. Bailis' last point. I do think as we move closer and closer and hopefully sooner to a totally capitated payment plan we will have erased a lot of the problems, whether they are by design or by default, that we have today.

In our own situation, the utilization of our skilled nursing facilities, be they either hospital-based or free standing, is very much driven by the growing managed care environment that we have in the Philadelphia area. It is also driven by the very appropriate up-

grading of those facilities and the kind of services that they can provide today as compared to what possibly a skilled nursing facility looked like 10 or 20 years ago. I think our physicians are much more comfortable that the level of support their patients need is now available in either kind of facility.

Again, the higher intensity needs of patients tend to be closer to home and in the hospital setting.

Mr. CHRISTENSEN. Mr. Lane.

Mr. LANE. On the comment with regard to hospital discharge, in the materials I submitted to the Committee I show with data specific to discharges from hospital lengths of stay in four different timeframes, 1980, 1981, 1984, 1988, and 1994. For individuals who are, in fact, discharged to the skilled nursing setting for specific diagnoses, those diagnoses account for approximately 50 percent of admitting skilled nursing facilities diagnoses today.

If you take the delta change from 1984 to 1994 of hospital days, that lengths of stay have been decreased because skilled nursing facilities have stepped up to take those heavier care patients. You will see a change in cost savings that could be estimated in the range of $1.5 to $2 billion. That, in essence, says that the policies that this Committee adopted during the late seventies and early eighties to deal with the access and to remove, to overcome the problems of admission to the skilled nursing setting, clearly did have some economic impact. And this is using some of ProPAC's data to, in fact, look specifically at diagnoses.

Now, that's been uneven in different markets. But it does show that there has been a tremendous improvement.

Mr. CHRISTENSEN. Mr. McMeekin, earlier Mr. Stark stated that a hospital may be kicking out a patient earlier and sending them to a SNF and, in effect, may be double dipping.

I guess what is your statement on that and have you, obviously, seen any effect of that going on in the industry, and what is your personal take on that?

Mr. MCMEEKIN. Well, I do not agree with Congressman Stark. I do not think——

Mr. CHRISTENSEN. I did not think you would.

Mr. MCMEEKIN. I think what we're seeing is, again, a recognition by our physicians, the ones who admit and discharge our patients from hospitals, that there is a very appropriate alternative in a skilled facility for a patient that has passed that very acute point of illness.

Hospital-based units are basically paid a lump sum and the ability to game is really minimized when you look at the reduction in the length of stay, and what little data seems to be available, that I think the ProPAC testimony talked about today, would not suggest to me that there is any gaming. I think there is an opportunity to put patients in more appropriate settings than there used to be. Again, as you move to prospective payment and then to a capitated payment system, whether I am right or others are right who feel differently, it all gets eliminated. And, that truly is the direction we need to move.

It's also why the American Hospital Association supports an interim step and is very happy to support the Subcommittee's inter-

est in looking at a prospective payment system for skilled care and home care.

Mr. CHRISTENSEN. Ms. Bailis.

Ms. BAILIS. Well, I think the use of the term, double dipping, carries with it a kind of willful abuse connotation that I think would be unfair to attribute to hospitals because I do not think that that drives the motivation.

I think the problem is that there are reverse incentives in place. And when you have, under one roof, cost-based settings and prospective paid settings, they are at war with one another in terms of the payment incentives and the result is that hospitals receive payments for services without a recalibration of the DRG that may be at times in excess of what would be an appropriate cost for the care of a patient. That may or may not be the case, but it certainly is open for that with the lack of alignment of incentives and payment systems that currently exist.

I suggest to you that payment be made irrespective of site of service, but really related to the type of patient, the care that patient needs and let the system and the market drive where that patient ends of getting the care, whether it is in a hospital-based SNF, a freestanding SNF or, for that matter, at home.

Mr. CHRISTENSEN. Mr. Vladeck, our first witness today—and I do not know if you were here for his testimony—but he talked about the HCFA looking at maybe moving to a continuous or holistic approach. How would that affect each of your industries?

Mr. MCMEEKIN. I, for one, would welcome it. I think it would move us dramatically in the direction of treating the whole patient, of looking at the Medicare beneficiary as really the focus of our payment system. As Ms. Bailis has already commented, I think it removes a lot of the artificiality that is currently at work in our payment systems today. I do not think it is by design but I do think it's just a product of the kind of system we have. And when we talk about the development of integrated delivery systems, as we're trying to develop in our community, and a continuum of services and then add, on top of that, a capitated payment for a population that you have responsibility for, you really align everything to provide the proper care in the right amounts in the right place at the right time in a way that, in my career, we have never yet been able to do.

So, I would support Mr. Vladeck and HCFA in trying to move us in that direction, and as well, the Committee. I believe Chairman Thomas has spoken very forcefully on provider-sponsored organizations and direct contracting where truly you can get enough of the premium dollar or the Medicare dollar, in this case, to then more appropriately spend it.

Mr. CHRISTENSEN. Mr. Lane.

Mr. LANE. I would express severe caution and reservation and it could be significantly disruptive in patient care. And dangerously reverse the incentive to move patients into the most cost-effective setting. It is noteworthy that in the private sector most payers do not premise payment for post-acute services on hospital reimbursement. That is because of three real issues. One that diagnoses is not a good predictor of post-acute services. Second, the hospital is, in fact, the highest cost model and you have a tendency to

medicalize services that may not necessarily need and have excess capacity. And the third is that, in many instances the hospital is not suited to deliver post-acute care.

So, I would realistically say to the Subcommittee that if we are going to focus on what can get done in a period of time to least disrupt care and yet bring appropriate service, to move forward with setting specific prospective payment system and see how that affects the system first.

Mr. CHRISTENSEN. Ms. Bailis.

Ms. BAILIS. The best way to really achieve a holistic model of care or an integrated delivery system is to pay all post-acute providers prospectively. And to introduce, in fee-for-service Medicare, some case management models of what assist in securing the best setting at the most efficient and high-quality result.

Managed Medicare already has essentially done that but clearly prospective payment system for all post-acute systems of care is the way to achieve that. I would suggest to you that the endless debating about how to do it, which has gone on for years, should at some point come to a halt and sometime or other we should just get on with it.

Mr. CHRISTENSEN. I want to thank this panel for their patience in waiting until the end of the day and thank you very much for your testimony.

This brings a close to this hearing.

The hearing is adjourned.

[Whereupon, at 5:33 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

**STATEMENT OF SHELDON L. GOLDBERG, PRESIDENT
AMERICAN ASSOCIATION OF HOMES AND
SERVICES FOR THE AGING**

INTRODUCTION

Mr. Chairman and Members of the Committee, I am Sheldon L. Goldberg, President of the American Association of Homes and Services for the Aging (AAHSA). I am grateful for the opportunity to submit testimony for the record of your hearing on Medicare Prospective Payment for Skilled Nursing Facilities and Home Health Agencies.

AAHSA represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Our membership consists of nearly 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community-based service organizations. With our broad range of facilities and services, AAHSA serves more than one million older persons daily. We have a long history and consequently, significant experience in meeting the needs of the elderly. We recognize the important role that the Medicare program has played in ensuring that the health care needs of older Americans are adequately met.

The future of the Medicare program will be affected by a rapidly growing population of elderly and individuals with disabilities, diminishing resources in the Hospital Insurance Trust Fund, and growing costs of providing medical care. This future presents many difficult problems that this Congress and the next must face, if the country is going to maintain its commitment to its seniors. We appreciate the competing and sometimes incompatible demands that you must reconcile in order to keep the Medicare program operating. We pledge to work with you in any way possible to control health care spending and reduce the national deficit while still preserving access to high quality skilled nursing, home health and other health care services for our nation's elderly.

Our members include not-for-profit home health agencies (HHAs) as well as skilled nursing facilities (SNFs) and my comments today generally apply to both types of providers, since many of the issues relating to prospective payment are similar. We will specify when referring to one type of service in particular.

LONG-RANGE VISION

Looking well into the future, we believe our members will be actively participating in managed care. They will be providing care and services financed by systems that coordinate care across time, place and provider. These systems will emphasize prevention, risk-sharing and

appropriate utilization of services based on consumer and community demand for maximum health and well-being at lower overall cost..

We see the beginnings of these systems now, as evidenced by the growth of managed care and Medicare beneficiaries' growing participation in Health Maintenance Organizations (HMOs). There is a greater use of cost-effective, post-acute services and fewer days spent in expensive, acute care hospitals by managed care enrollees. Managed care organizations already receive substantial cost savings from the use of sub-acute care services without a three day prior hospital stay and from the substitution of post-acute care for unnecessary hospital days. Unfortunately, the Medicare program can not reap the same savings from these trends.

MEDICARE SAVINGS PROPOSALS

We have two savings proposals for your consideration. First, the elimination of the three day prior hospitalization requirement for selected diagnoses and second, the recalibration of acute hospital prospective payment rates, based on current lengths of stay. These two changes would permit Medicare to accrue savings from the growing use of cost effective post-acute services instead of more expensive acute care hospitals.

A third opportunity for savings comes through the Program of All-inclusive Care for the Elderly (PACE) demonstration and some waivers for Medicare and Medicaid, such as the Minnesota Senior Health Options Project. These are innovative approaches to integrating funding and services to enhance the quality of care available for seniors and they have the potential for cost savings, as well. Facilitating the waiver process for states would permit greater experimentation and flexibility in the treatment of beneficiaries who are eligible for both programs. Lessons learned from these demonstrations also reveal opportunities for savings in the Medicare program.

Superficially, the proposal to bundle payment for all post-acute services with the prospective payment to the acute care hospital may seem to provide for that type of substitution and savings. However, in reality, it would create distortions in the marketplace and would shift control of patients back to the hospital. Hospitals would have an incentive to retain relatively lower cost patients in their own nursing units and to discharge relatively higher cost patients to free-standing facilities, but their incentives concerning payments would be to retain more money to cover their own higher cost nursing units and to contract with free-standing facilities at reduced rates. The trend towards integrated delivery systems, combining

primary, acute, post-acute and long-term care providers with case management and equitable sharing of risk, has a greater potential to improve the quality of care delivered to beneficiaries and to produce savings. This is mainly because there would be no bias towards the most expensive providers.

We recognize that, in the short-term, reform of the current retrospective, cost-based reimbursement system is inevitable and that some form of prospective payment is likely. The Medicare PPS for low-volume SNFs is a start that has been working fairly smoothly, but it is only a first step. A well designed PPS could promote management efficiencies and create some savings for the Medicare program. But a poorly designed PPS could mean unintended consequences that might not help the Medicare program, its beneficiaries, or the long-term care industry.

We have seen from the implementation of the hospital PPS that the health care industry is very complex and can react in unexpected ways to PPS incentives. For example, the reduced hospital length of stay was an anticipated and desired result of PPS implementation. With hindsight, the growth of subacute care based in hospitals seems a natural result, but it was not as clearly expected at the time of implementation.

We understand that health care providers cannot continue with a "business as usual" attitude. It is also important for Congress and the Administration to understand that, with current major cutbacks in state Medicaid programs and the growth of managed care, SNFs and HHAs will not have the flexibility to cross-subsidize unreimbursed costs for Medicare patients with revenue from private patients.

Our members are committed to providing the highest quality care and living environments for their residents and patients, often exceeding the federal standards and requirements and providing more than the minimum care and services. High quality, however, does not come cheaply. With strong community support and charitable contributions our members have been able to provide more care and at more affordable rates than would otherwise be the case. But there is a limit to how much of the gap can be filled by development activities. An adequate level of compensation for residents and clients financed by public programs is essential.

PROSPECTIVE PAYMENT GOALS

While the most immediate objective for initiating a prospective payment system (PPS) may be to produce program savings, it certainly is not the

only one. Following are some other goals that ought to be included when designing a new reimbursement system.

- Access to care: The PPS should facilitate the timely movement of Medicare patients from acute care to the appropriate post-acute care setting. Reimbursements should not be set so low that providers would be reluctant to accept patients with high acuity, needing relatively intense or lengthy courses of treatment.

- High quality care: Ideally the PPS should reward high quality care and focus on quality outcomes.

- Efficient use of resources: The PPS should encourage efficiencies while recognizing that circumstances will vary from one provider to another and will affect management choices. The choice of service setting or provider type as well as the specific mix of service to be offered to a beneficiary should be encouraged to reflect the efficient use of resources as well as medical necessity and patient choice.

- Ease of administration: The current system of cost reporting with retroactive adjustments, audits, and settlement delays is cumbersome and costly. Management of the program by Medicare and of the service by the provider should be greatly streamlined.

- Innovation: Given the current dynamism of the health care market, the PPS should not lock-in the status quo, rather it should permit and encourage innovation and change. It should also recognize the costs of compliance with any new federal requirements, such as changes in the minimum wage or OSHA.

UNDERLYING ASSUMPTIONS

Basic to the achievement of these goals are some important underlying assumptions.

- Skilled nursing facilities must rehabilitate Medicare beneficiaries in their care to the highest practicable physical, mental, and psycho-social well-being. This is federally mandated by OBRA '87.

- In general, Medicare payment for nursing care and home health services should approximate the reasonable costs of efficient providers. It does not matter how finely constructed are the incentives of the PPS, if there is not a realistic level of funding in the system.

- There are some legitimate differences, such as labor market wages, in factors affecting provider costs that are to be expected.

- Not all costs of producing services can be controlled directly by management.

- It must be recognized that the growing expenditures of the Medicare program result not only from provider actions that can be corrected by a PPS, but also from growing numbers of beneficiaries with greater needs for services.

ELEMENTS OF THE PPS

Case Mix Adjustment: Basic to the achievement of almost any of the goals mentioned above is the ability of the PPS to discriminate among patients requiring different levels and types of care and associating that with the resources used in treatment. In other words, residents or clients requiring more expensive and extensive courses of treatment should generate a payment amount greater than the average patient. Likewise, a relatively easy care patient should generate a payment less than the average. However, there should also be an incentive to rehabilitate the patient and move a high acuity patient to a higher functional level with a less intense level of service needed.

In the acute care hospital, prospective payment per case is set by diagnosis, but a classification by diagnosis for post-acute care is not a good predictor of resource use. Functional limitations are a better indicator of costs of care within a given post-acute care setting (SNF or HHA). HCFA has a Multistate Skilled Nursing Facility Medicare Case-Mix Demonstration currently underway. Soon, HCFA should be receiving data on case mix adjusted payments for SNF care that includes some ancillary costs along with routine costs. However, the project is very limited in the number and geographic spread of participating facilities as well as limited in the costs covered. The evaluation data will not be available in the near future. A case mix adjuster for HHA patients is also far from fully developed although the second phase of a demonstration project is in operation. There is not yet a case mix adjuster that explains a significant amount of the variation in costs per case. It is essential that case mix adjusters for both HHAs and SNFs be developed, refined and tested as quickly as possible.

Unit of Payment: The most commonly mentioned units of payment are: episode/case/stay and per diem/visit. While it is relatively straightforward to define a visit or day for payment purposes, defining a post-acute case

or episode of care or a SNF stay becomes more complex. Care of a Medicare beneficiary in a post-acute setting can be punctuated by an acute incident requiring temporary hospitalization and then a return to the same or a different SNF or HHA. Or, a resident may leave the SNF to return home, have a relapse or find it impossible to manage at home and then return to the SNF. Likewise, a HHA client might stop service for a period, either because of an acute or post-acute care admission or for lack of continuing need, but then return later to HHA care for the same diagnosis.

Defining and keeping track of a beneficiary's treatments during an episode of post-acute care requires very sophisticated and integrated information systems. Even with a clear definition of episode, it will be difficult determining norms for payment purposes. The appropriate, medically necessary post-acute care course of treatment can vary significantly, even for patients with the same diagnosis or functional level. In addition, the social and family supports and personal preferences of a beneficiary can affect the length of treatment and setting. Again, the case mix adjuster becomes crucial for differentiating between the amounts of care needed by beneficiaries and for defining the episode and payment level appropriately.

The choice of payment unit affects the incentives of the PPS. These incentives would need to be carefully balanced with an effective quality assurance/outcomes monitoring system. With a payment per episode there would be an incentive to reduce/eliminate unnecessary services. Similarly, it could provide an incentive for underservice or early discharge. For home health, in which Medicare's concern is with an increasing proportion of cases receiving long courses of treatment with many visits, a payment per episode would be appropriate. However, such a mechanism to control volume of services in the home health setting would need to be balanced by effective monitoring of quality and a payment process for exceptional cases.

The choice of a unit of payment is less obvious for SNFs. After observing the trend in hospitals over the past dozen years since implementation of a PPS based on episode, to discharge patients "quicker and sicker", we should approach that method with caution for SNFs. There is no evidence of an increase in the average length of stay of Medicare nursing home patients or of dramatic increases in the proportion of beneficiaries using SNFs. Medicare's concern with the growth in the number of therapies/ancillary services could be met with a per diem payment. In addition, the SNF Medicare benefit has a limit of 100 days (unlike the unlimited HHA benefit) and the copay of $92 per day after the 20th day may help deter unnecessary utilization. Methods of phasing in an

episodic payment or blending it with a per diem payment should be explored, given Medicare's lack of a sophisticated and accurate case mix adjuster and refined quality outcomes monitoring systems.

Covered Costs:

Ultimately, the PPS should include all costs related to caring for Medicare beneficiaries: routine, capital and ancillary costs for a SNF and visit, travel, and administration costs, etc. for a HHA. However, a phased-in approach, perhaps covering only routine costs initially, until complete data are available would make more sense at the start of a PPS. A comprehensive payment is more attractive administratively for the program and the provider, facilitates planning and permits flexibility of operations. However, an all-inclusive payment presumes a knowledge of all the components of care and associated costs that currently go into an episode or day of care and a norm of what volume of service ought to be included. That information and understanding is not yet available.

Even with the case mix demonstrations, HCFA will not have complete data on all the ancillary services and supplies and their costs that are currently associated with particular categories of cases. Treatment protocols and clinical pathways for common post-acute diagnoses are still under development. It will be difficult devising reasonable assumptions about length of stay/number of visits, and appropriate ancillary costs to cover in an all-inclusive payment. This again would argue for a phased-in approach.

Inflation Factor: Any PPS must recognize the impact of inflation on the provision of services. The "market basket" approach used for the Medicare low-volume SNF/PPS makes sense. However, the projections and updates should be made in a timely fashion to assure their accuracy and close proximity to reality, since a retroactive adjustment for inaccurate projections would be counter to the prospective philosophy.

Since the design of the PPS is predicated on the assumption of a realistic level of payments, it would be a gross distortion of the system to use the inflation factor as a mechanism for reducing the payment level to meet arbitrary congressional or administration budget constraints. The ease of abusing the inflation factor, for example, by setting it at market basket minus 2% shows a clear disregard for the goals of PPS and makes the industry leery of supporting any reimbursement change.

Other Adjustments: Geographic adjustments are important for recognizing variations in costs affected by place of service (urban/rural)

and costs of labor in different markets. Such adjustments are included in the low-volume Medicare SNF/PPS and the hospital PPS system and appropriate mechanisms should be included in any new PPS system.

In keeping with the goal of matching the payment amount to the acuity of the case and level of services needed, we recognize the need to eliminate the differential payment for hospital-based SNFs.

Outliers: Even with a sophisticated, fully tested case mix system, there will be a need for recognizing exceptional cases requiring substantially more services than the norm. With a crude system still under development and not fully tested, the exceptions process becomes even more important. This is particularly true with respect to home health, where the benefit is not time or visit limited.

Waiver of Liability: Given the complexity of Medicare's eligibility rules and definitions, providers of service need the reinstatement of the waiver of liability, whether the payment system is retroactive or prospective. This is necessary to protect innocent, careful providers who unintentionally and on rare occasion, make a coverage mistake and to ensure the timely availability of services to beneficiaries.

CONCLUSION

We recognize the need to move forward with a new and improved payment system to cover Medicare SNF and HHA patients. Well designed and implemented Prospective Payment Systems for all SNFs and HHAs could meet many of the needs of the program as well as of providers and beneficiaries. We are concerned, however, about imposing too rapidly any system that has been inadequately tested and is based on insufficient data. In conclusion, we recommend:

- The collection of necessary cost and utilization data and the evaluations of the demonstrations as quickly as possible,

- Any PPS be phased-in to permit smooth implementation and the avoidance of drastic and inappropriate changes. The PPS could cover gradually increasing categories of costs or could be a blended rate based on a provider's current payment and the new PPS rate.

- The full PPS include monitoring of program implementation to spot potential problems early. Also, it should include evaluation of the implementation phases and their impact on the health care industry broadly and on SNF and HHA providers, beneficiaries and their quality

of care and the quality of life, in addition to their impact on Medicare's budget. Changes and revision of the PPS should be expected based on the evaluation.

- The three-day prior hospitalization requirement be eliminated for selected diagnoses,
- The PPS payments to acute care hospitals be recalibrated to reflect more accurately current lengths of stay,
- The Waiver of Liability be reinstated, and
- Waivers for Medicare and Medicaid integration and programs such as PACE be facilitated.

We look forward to working with you in the months ahead to help develop a payment system that will work for Medicare, its beneficiaries, and the whole industry. Thank you for this opportunity to present the views of the not-for-profit nursing facilities and home health agencies who are members of the American Association of Homes and Services for the Aging.

Statement of
Dwight S. Cenac
Chairman of the Board
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Submitted to the
The Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

On Issues Related To Home Health Agencies and Skilled Nursing Facilities

August 5, 1996

Mr. Chairman and members of the Subcommittee, on behalf of HCAA, I am pleased to have the opportunity to share our views concerning the critical issues related to Medicare payment policies for post-acute care services, especially home health care. I would like to begin by commending Chairman Thomas for convening the July 23, 1996 hearing to address the critical need to control the rate of growth in Medicare spending, while assuring that necessary services will be provided to the most vulnerable members of our society, our nation's elderly. HCAA applauds and embraces these attainable goals.

HCAA represents the voice of 300 freestanding home care agencies. I attended this important Subcommittee hearing on behalf of HCAA; listened to and read the testimonies and statements given; and heard the questions raised by members of the Subcommittee. Accompanying me was Scott Lara, HCAA's governmental liason-representative.

This submittal is divided into four sections: Section I - What This Subcommittee Can Do Now; Section II - Our Response to Questions Raised by Members of the Subcommittee, Which HCAA Feels Were Not Appropriately Addressed; Section III - A Comparison of HCAA's "Per-Visit" PPS Plan to "Per-Episode"; and Section IV - Other Issue.

Before beginning, HCAA would like to clarify that the "Revised Unified PPS (Home Care) Plan" presented to the Subcommittee **does not have the endorsement** of the only two national associations exclusively representing freestanding agencies; nor does it have the endorsement of our respective state chapters. Noticeably absent from their "Declaration of Support" are the signatures of both HCAA and the American Federation of Home Health Agencies, AFHHA (AFHHA, similar to HCAA, is the other national trade association representing an equally large number of freestanding agencies.). HCAA would like to be included, as a witness, in future meetings/hearings on home health care. We are concerned that, although freestanding agencies represent the largest group of providers, the list of "home health care" witnesses (excluding the AHA) testifying before the Subcomittee consisted of two VNAs and one chain--there was no home health care representation by freestanding proprietaries. While we support the right of other associations to have their voices heard, HCAA is compelled to ensure fair representation of our members' values and beliefs and of the rights of their patients. We believe that fair representation is also necessary in order for the goals of this Subcommittee to be effectively accomplished.

SECTION I - WHAT THE COMMITTEE CAN DO NOW

(a) Stop Fraud and Abuse Enforcement---How? Have Industry (Preferrably AHCA and HCAA) Representatives on ORT task force and place limits on ORT over-zealous surveyors.

(b) Stop Improper Hospital "Double-Dipping" (Once in their DRG "charge" based rates and then again in their SNF and Home Care

"cost" based rates). --- How? By eliminating the allowablity of Hospitals Administrative & General cost allocations to their Hospital-Owned SNFs and Home Care Facilities.

(c) **Stop Inappropriate Hospital "Self-Referrals" --- How? By requiring HCFA to enforce 42CFR 424.22 against Hospital-Owned agencies who are violating the Law.**

(d) **Stop Unjust Cost Caps (that currently propose home care skilled nursing and home health aide Cost Cap Limitations, for all agencies nationwide, at levels BELOW Pre-Freeze levels). ---How? Instruct HCFA that when such a condition exists, Cost Caps must be made equal to Freeze levels.**

SECTION II - ANSWERS TO COMMITTEE QUESTIONS

Conspicuously absent (and troublingly so) were critical home health care industry insights and responses to the Subcommittee questions on such key payment issues as: (a) fraud enforcement; (b) improper hospital "double-dipping;" (c) inappropriate hospital self-referrals; (d) and the need to stop unjust 1996 cost cap limitations which are LOWER than the 1993 freeze levels.

(a) Fraud and Abuse Enforcement- ORT & Need For Industry Input

No one industry organization has shown more concern over fraud and abuse in home care than HCAA. In fact, HCAA's Chairman, Dwight Cenac, delivered a scathing report to HCFA on November 11, 1992 pinpointing abusive activities by both ABC (a $600-million, 400-office chain operation) and other mega agencies utilizing subcontracted staff at greatly inflated prices. In a subsequent telephone follow-up, Mr. Cenac queried HCFA's Mr. Eric Yospe, a HCFA official bearing some responsibility for the audits of home care expenditures nationwide, on dealing with these abusive issues, and provided him additional information on how a major abuser of subcontract services in Miami, Florida (Hospital Staffing Services, Inc. (HSS), a $90-million, multi-office chain) was improperly milking the Medicare program millions each month. For the most part, the activities reported by Mr. Cenac were discarded by HCFA--although, MUCH LATER, a great deal has been said to Congress about these activities; and no credit has been afforded to the freestanding agencies for our attempts to help police such mega felons. In fact, years before the OIG prosecuted these felons, HCFA's Yospe stated, in response to the allegations of impropriety raised by Mr. Cenac, that HCFA had no way of ascertaining the fair value of subcontracted services; and that there was nothing wrong with HSS 's exclusive utilization of subcontracted nurses--even after he was informed by Mr. Cenac that such subcontracts were from seperate corporation(s) *OWNED* by the referring physicians. What is greatly troubling to HCAA is HCFA's and the OIG's misrepresentations that freestanding proprietaries (who generally bill less than $10 million annually) are, somehow, similar to these mega chains and self-referring physcian practices; and, somehow, should be subjected to increased scrutiny--now under the umbrella of ORT--because of such felons. HCAA is not opposed to investigations of fraud and abuse. In fact, as stated above, HCAA has attempted to bring such issues of fraud and abuse into light--**years before they were brought to Congress, or for that matter, before the felons caught.** What HCAA is opposed to, however, are two issues: first, the unwarranted singling out of freestanding agencies--while, at the same time, the unwarranted selective exclusion of HMOs, hospital-owned agencies and chains from ORT's process; and second, the improper use of excessive force by ORT's inexperienced and overzealous surveyors aimed at expelling freestanding agencies from Medicare participation by improperly interpreting **guidelines that they are NOT similarly and simultaneously applying against hospitals and chains.** It is in this **spirit of fair play** that HCAA appeals to this Subcommittee (1) to properly and uniformly channel the ORT task force; and (2) to request the incorporation of valid industry input, such as HCAA, into the selection and investigation of today's sophisticated health care thief. Although **Peg Cushman** testified on behalf of NAHC and the home care industry, she later

told HCAA that NAHC's legal counsel, **Mr. Bill Dombi**, failed to notify her of the ORT abuse hearing he attended on behalf of NAHC member CSM (a freestanding agency in California). HCAA was concerned regarding the failure, in the testimony given, to reference the real attrocities occuring against the freestanding agencies under the umbrella of ORT. CSM Home Health Services, Inc., is a 10-year-old Los Angeles agency, which has spent more than $60,000 on legal and consulting services to fight its improper Medicare decertification after an ORT survey. One independent home care news reporter stated that the CSM story is not new--in fact, "In California, 26 of 40 planned surveys were completed last month. Six agencies were decertified; three voluntarily withdrew from the Medicare program; and one filed for bankruptcy. Think that because you're not in one of Operation Restore Trust's five targeted states, you'll escape its increased scrutiny? Think again. The latest state to be snared by the fraud initiative is Tennessee." **The presiding judge over the CSM case, the Honorable John G. Davies (Case No. CV 96-4651-JGD),United States District Court -Central District of California, could find no legal grounds (this is precisely why this Subcommittee's intervention is needed) to grant CSM relief, although he definitlely wanted to. Judge Davies said of the ORT process, "I think the surveyors -- I think CSM Home Services has a case. The evidence that is before me that I have perused, read, considered, leads me to those conclusions. The Surveyors, I had the Impression, were not reticent to wear their power on their cuff and to manifest it and exercise it in ways that are undesirable in today's society. The bureaucracy overreacted once again. That is my view of this case. But, what relief can I give you?"** What follows is a portion of the sworn testimony of one of CSM's key employees. It is given this Subcommittee as a reference point of the type of agency being abused by the unbridled ORT process, as it currently operates. "I, Jean R. Murphy, R.N., have been a registered nurse for over twenty years, a portion of which was served as an officer and flight nurse in the United State Air Force. I have approximately thirteen years of experience in home health care as an administrator and/or consultant. I am currently administrator of CSM Home Health Services, Inc. I have held this position for four years. CSM has been serving Los Angeles' underserved minority communities since 1985. These communities include the Rampart District, South Central Los Angeles, Koreatown and other primarily minority communities. ***CSM's clerical and field staff are also primarily minority. CSM staff continued to serve their clients during the 1992 riots under security guards. During the Northridge earthquake, my staff forsook their families to rush to the aid of their patients. One black certified home health aide was present in a board and care facility during the earthquake; and placed several residents under mattresses to protect them as she, herself, braced and quieted their fears. The CSM Director of Nurses stood in water without power using her cellular phone to try to reach staff and patients to ensure their safety, despite the fact that she, herself, was in peril because the gas supply in her apartment had not been turned off and had been evacuated for fear of explosion. One of CSM's clinical supervisors was carjacked and robbed at gunpoint while she sat in her car solving a patient crisis on her mobile phone. Another registered nurse, whose husband had driven her to a patient's home after the riots, was shot as they sped away to avoid being carjacked or killed. CSM has undergone Medicare recertification surveys annually since its founding. These surveys have been conducted by the surveyors from the Department of Health Services, who have found only minor deficiencies with CSM's compliance with Medicare Conditions of Participation. CSM responded to these deficiencies with corrective action plans; and there have never been any termination actions initiated against CSM as a result of these minor deficiencies."***

HCAA asks the question: Does the Subcommittee believe that CSM is the type of agency at which ORT should be targeted?

For the record, below is a sampling of the ORT findings used against CSM, as the basis for booting CSM out of Medicare (None of the findings were related to patient care--odd isn't it?):

G104 - Standard: Exercise of Rights and Respect for Property and Person. The surveyors alleged first that there was a conflict between CSM's admission consent form and CSM's patients right form. CSM believes that it was in full compliance with this standard at the time of the survey, since the general consent form simply authorizes the agency to begin treatment; and the patient rights form gives the patient the right to refuse any specific treatment at any time. However, CSM amended both of these forms to comply with the surveyors' expectations. The

Surveyors also alleged that CSM had deficiencies in informing patients of the State home health hotline number, because some of the patients could not explain to the surveyors the purpose of the hotline. However, the regulation requires only that the hotline information be provided to the patients in writing. Upon admission, CSM provided (verbally and in writing) all of the information regarding the hotline number to each of the surveyed patients.

G108 - Standard: Right to be Informed and Participate. The surveyors alleged that CSM was not in compliance with this standard because one patient claimed that he was not informed of his patient rights and was not included in the plan of care. However, CSM had documentation that this patients had signed a patient's rights statement; and, therefore, was informed of his rights. Surveyors also alleged that one patient was told by a physician that he wanted the patient to be referred to CSM. CSM did not condone or request this action by the physician; and, therefore (I believe) cannot be held responsible for the physician's actions. Further, this alleged problem does not appear to be covered by this regulation; and, therefore, CSM was not out of compliance with this Standard.

Other issues cited by the ORT surveyors were similar AND were not patient care issues

HCAA is not alone in its concerns and observations regarding the need to oversee such ORT policies. *Testimony given by Susan Bailis, AHCA, states that the Subcommittee should "carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, and are not abused by over-zealous inspectors and are enforced fairly and evenly."*

The final comparison I would like to make, to what is happening in the ORT process, was best stated by Ann Chadwell, Knight-Tribune News Service. Ann states that, *"Behavior that is high-handed and harsh from people in control toward people economically beholden and unable to fight back is cheap."* Ann shared a story to make her point: "There's a great story about passengers mobbing the reservation counter after a cancelled flight. Airline personnel were doing their best to rebook passengers quickly. A demanding passenger pushed to the front of the line, pounded on the counter and shouted repeatedly, ' You have to get me on this plane.' The reservationist remained accommodating and unrattled. The passenger's tirade became even more incensed and insulting. 'Do you know who you're talking to?' he shouted. 'do you know who I am?' The reservationist calmly took the microphone and announced over the intercom, 'We have a passenger who doesn't know who he is. Will someone who knows this passenger please come identify him?' That caused the other passengers to erupt in applause." **This fine example was given to me by my thirteen-year-old son, Dwight Cenac II.** I believe that **America would cheer** a Subcommittee which properly brought back into-line an out-of-order bureaucracy which has lost touch with the issues.

(b) Hospital "Double-Dipping" - Overcharging Medicare Billions (for HHA and & SNF Covered Services)

One committee member repeatedly asked the NAHC and PPS Work Group home care representaives about the impact of hospital "double-dipping" and self referrals (See section (c), below, for our separate concerns on self-referrals.) upon the home health care industry and upon their PPS "per-episode" proposal. I believe most agencies would be shocked to hear that the only response given was by Mr. Hoffman (one of the two spokespersons for the PPS work group), who stated, "I have never given it any thought." This is a most incredible response, given the massive amount of adverse publicity this activity has received in Texas (Mr. Hoffman's state of residence). HCAA does not concur with such unreliable testimony. Today's flawed reimbursement to hospital-owned agencies (and SNFs) essentially allows hospitals to commit legalized fraud/abuse by "double dipping" Medicare funds. Today, hospitals are rapidly jumping into home health care and unethically blocking referrals to freestanding agencies because they've discovered a reimbursement loop-hole that allows hospitals to get paid twice. They are able to do this **once** with their Medicare DRG rate, which includes their administrative costs, and **then** by allocating this very same administrative cost to their hospital-owned agency. In fact, hospitals are even purchasing agencies whose owners have been convicted of fraud (such as Health Masters).

Hospital Medicare reimbursement needs to be changed to stop hospital administrative "double-dipping," falsely called "cost shifting." A "cost shift" means just that! It means **shifting** a cost **to another location**. It does **not** mean "**duplicating**" the cost somewhere else! Patients were supposed to be guaranteed a choice of health care providers! HCAA findings can best be compared to the testimony given by Susan S. Bailis, representing 11,000 freestanding SNF's who are members of the American Health Care Association (AHCA). Ms. Bailis shared in her testimony the need to stop rewarding inefficient hospitals through Medicare's failure to recalibrate DRG's (improperly allowing hospitals to double-dip Medicare in the SNF market as well). HCAA shares Ms. Bailis's concerns about HCFA's unwarranted "desire to continue to subsidize less-efficient and more-costly hospital-based care." Identical to HCAA's concerns, Ms Bailis testified as to "incentives for hospitals to allocate labor, administrative, and general costs over to PPS-exempt SNF units (one Executive identified $50,000 per bed as a common figure); and the ability of hospitals to receive a cost-based payment higher than a freestanding SNF, in addition to the full DRG payment,". AHCA proposed, and HCAA agrees, that hospital "DRGs be examined and recalibrated according to severity of illness and length of stay." Although most experts (including testimony by Ms. Bailis and testimony by Joseph P. Newhouse Ph.D., Chairman of ProPAC) agree that the recalibration of DRGs is needed, they seem to be at a loss with regard to how to get it done. HCAA proposes, therefore, that the only other appropriate interim solution is to simply STOP the hospital's double-dip allocation (to Medicare), of its administrative costs (already included in its charge-based DRG), to cost-reimbursed home health care or SNF care rendered in facilities owned by the hospitals. HCAA has calculated that Medicare could save $1.2 Billion annually (in the home health care market, alone) by stopping this double dip. AHCA calculates that Medicare could save "$9 Billion per year (in the SNF market)!"

(c) Improper Hospital Self-Referrals

Again, HCAA is concerned over the lack of response, given by the home health care representatives who testified, to Subcommittee members who questioned the guerilla-like self-referral tactics hospitals are, allegedly, utilizing to pirate referrals **away from** freestanding agencies **into** their hospital-owned home care facilities. The issue of self-referrals should be of keen interest to this Subcommittee for the following four key reasons:

(1) Self-referrals cost Medicare significantly more.

This subcommittee has already received testimony to the effect that home care, provided by hospitals, costs more. Evidential testimony was given to this effect by HCFA, ProPAC, AHCA (similar SNF substantive testimony), and even the AHA which (unbelievably) petitioned to keep such overcharges legal.

(2) Self-referrals create inappropriate market dominance and deny patient choice.

The best response was made by AHCA, which testified that such inappropriate rules are "directly attacking our ability to compete in the sub-acute Medicare marketplace."

(3) Self-referrals (from physicians) have already been legislated as Non-Allowable (But HCFA refuses to enforce this Regulation when it applies to hospitals.).

Unfortunately, HCFA has chosen to unfairly **not enforce** 42 CFR 424.22 in a even-handed manner against hospitals which violate this significant policy. Specifically, 42 CFR 424.22 prohibits Medicare (HCFA) from paying claims to hospitals (and all other home health care agency types as well) for any home care referrals received from physicans compensated more than $25,000 annually.

(4) Self-referrals create overutilization (and hence costs) of home care services .

Surprisingly, no one testified before this Subcommittee on ProPAC's finding of hospital

overutilzation of home care services WHEN they own the home care agency they self-refer to. **The June 1, 1996 "Report To Congress" submitted by Joseph P. Newhouse, who testified before this Subcommittee, stated that, "Hospital-based providers also were likelier than free-standing ones to treat beneficiaries who had been in the hospital."**

The vital issue of abusive hospital self-referrals is not as prominant in SNFs as it is in home care. We believe this is so because patients are normally familiar with the differences between a freestanding SNF and the hospital's; whereas such familiarity is not known for home health care. The primary reason that self-referrals is such a critical issue in home health care is because hospitalized elderly patients are victimized, by hospital staffers, into believing: first,that the hospital is the only provider; and second, that only the hospital-owned agency is capable of giving them the specialized care they need once they are discharged to their homesetting. The issue compounds itself because hospitals are purchasing physician practices and then mandating the physicians to self-refer to the hospital's owned agency. This "purchased" physician self-referral practice is **supposed to result in denial of claims**, based upon 42 CFR 424.22. Enforcement of 42 CFR 424.22 clearly falls into the jurisdiction of HCFA as it is a claim-denial issue, not a fraud issue--**and on June 18, 1996, the OIG brought this to HCFA's attention!** Specifically, the Chief Counsel to the Inspector General, D. McCarry Thornton, "copied" HCFA's Thomas E. Hoyer stating, "HCFA has the responsibility for enforcement of these regulations." *Eli's Home Health Care Report* stated that after the Thornton letter, HCFA itself will not issue further clarification on the issue. "They're going to adhere to their current interpretation (meaning hospitals are not permitted to self-refer) and their current 'enforcement' (which means no enforcement of the Law against hospitals), one source says." Another, notes that "*HCFA will now let the courts decide* the extent to which 42 CFR should be enforced (even though HCFA has made NO disallowances against violating hospitals) and whether or not hospital-based agencies should be granted a moratorium, as they have requested. 'Whether HCFA is going to do anything more than it has in the past, such as disallowing these claims, I don't know,' adds Pyles." HCAA has asked for a meeting with HCFA's chief, Dr. Bruce Vladeck, who testified before the Subcommittee, to uncover the truth as to why his office will not enforce 42 CFR 424.22 in an even-handed manner. However, Vladeck privately told HCAA that he **will not meet on this matter. HCAA feels it is imperative that this Subcommittee require HCFA to even-handedly enforce the regulation (42 CFR 424.22) against violating hospitals; and then, if necessary, let the courts decide. To be fair to the hospital industry, HCAA would request that the Subcommittee require HCFA to first, and immediately, instruct its Contractors and Intermediaries to notify hospitals about this potential liabilty; and then, make disallowances for referrals from physicians whom they compensate, directly or indirectly, over $25,000 per year.** HCAA wishes the Subcommittee to know that this vital issue (self-referral) is not one evolving from the interest of hospitals in patient care, as there were few hospitals rendering home health care before DRGs. **The issue is clearly one created by the hospital's ability to be paid twice (see (b), above, on the "double-dip") and to get paid "twice as much" by (improperly) monopolizing referrals.** Specifically, there are two well-known industry suits recently filed (in Texas) against Columbia/HCA on the very issue of hospital improper self-referrals. One suit is a "whistle-blower" action filed by Dr. James Thompson, a family practitioner in Corpus Christi, Texas, contending, according to a November 11, 1995 Associated Press story, that "Columbia-HCA Healthcare Corp., the nation's biggest hospital chain, paid doctors illegal kickbacks (including cash, free vacations and cheap office rentals) in exchange for patient referrals". The second is a class-action suit filed on January 17, 1996, again, against Columbia-HCA, by a freestanding proprietary agency (CHS of El Paso,Inc - El Paso, Texas) alleging that Columbia-HCA owns four hospitals in El Paso and is employing monopolistic practices by having "pressured physicians with staff privileges" and "profit incentives" if they'll stop referring patients to CHS companies. These instances of impropriety are far from alone. Some further examples of such hostile self-referral hospital tactics are recounted here as quoted form the June 3,1996 issue of *Eli's Home Health Care Report*: *" 'As we continue to see more hospitals get involved in the home health side of the business, outside the confinement of the hospital, our referrals continue to dry up,'* notes Glen H. Beussink, Executive Director of Cape Girardeau, MO-based home care provider Health Data Services, Inc. Marilyn LeVasseur, MS, RN, Administrator of Family Nurse Care in Brighton, MI, also says that her revenues have been hurt by a local hospital's getting into home care business. *' In April of this year, the only hospital in the county became affiliated with a multi-hospital organization, and our referrals decreased*

30 percent,' LeVasseur says. According to Beussink, *'many of the physicians are pressured ever so slightly to use the hospital services. '* The American Federation of Home Health Agencies (AFHHA) also notes that *'we have received many reports that physicians have refused to sign home care orders unless the patient agrees to use the hospital-based home health agency.'* The National Home Infusion Association (NHIA) agrees, noting that '*our organization routinely receives calls from both outpatient providers and physicians indicating that hospitals are increasingly pressuring physicians and patients, both directly and indirectly, to utilize the hospitals' own services. '* Phyllis W. Fredland, RN, Director of Nursing for Health Personnel Incorporated in McKee's Rocks, PA, also observes that *'here in Pittsburgh, if doctors refer to another entity outside the hospital, the hospital can revoke their privileges. 'In our area, they are nothing less than predatory.'* According to Robert J. Brock, vice-president of At Home Health Care in Redwood City, CA, *hospitals 'discard literature we deliver to the hospital."* HCAA uncovered another contemptible tactic used effectively by hospitals to prey on their medical staff employees. In a misleading letter to home care agencies in its California community, Scipps Memorial Hospitals, in San Diego, California, stated, "It is the intention of Scripps to give to our patients reasonable choice in their selection of healthcare providers." The real truth of its intentions is shown, however, in its February 16, 1996 secretive internal memo written to its Medical Staff (as a basis for restricting freestanding home care agencies from receiving referrals). It read, "We believe it is critically important to keep patients within the Scripps health system whenever possible. This enables Scripps to deliver its premier quality care while assuring continuity of patient care throughout the system. When patients leave the system and are enrolled in other home care agencies, we lose jobs for Scripps employees, dollars for the Scripps system, and risk adverse patient outcomes as a result of care that may be less than the Scripps standard." Caught red-handed in its deceit, Script gave this arrogant, and yet weak, defense for its actions: alleging that, somehow, **care given by others is not up to its premier standards (forget Medicare's)**, "patients are encouraged to use Scripps' facilities because the recommending personnel have first-hand knowledge of the quality of those services."

d) Stop Unjust 1996 Cost Caps Lower Than 1993 FREEZE Levels

In his closing testimony, HCFA's Bruce Vladeck told the Subcommittee, "Let me end the home health discussion with a note of agreement. Both the Congress and the Administration wisely proposed to permanently extend the savings from the OBRA-1993 freeze on home health cost limits by not allowing for the inflation that occurred during the freeze. In the absence of this legislation, spending reverts to pre-freeze levels." However, Mr. Vladeck and others who testified failed to address the actual horrifying new Cost Limitations as published for comment in the Federal Register dated Monday, July 1, 1996. When directed by Subcommittee member, Jim McCrery (R.-La.) on whether he (Vladeck) understood that the Subcommittee's intentions were to control the growth rate of Medicare Expenditures, and not to "cut" Medicare expenditures to home care, Mr. Vladeck stated that he understood. What he failed to point out to the Subcommittee was that HCFA's currently-proposed skilled nursing and home health aide Cost Limitations, for all agencies nationwide, were SIGNIFICANTLY BELOW Freeze levels (thereby, representing a "cut" in home care expenditures and not a control on the rate of growth). Clearly, the proposed Cost Limitations do not meet the stated goals of the Subcommittee; and are unduly harsh and punitive, given these astonishing post-freeze results of HCFA's proposal. Whether HCFA's July 1, Cost Limitation findings are in compliance with statutory directives cannot be HCFA's shielded response when HCFA's results are so improper when compared to Congress' intention--as stated in this Subcommittee, and as agreed to be fully understood by HCFA's chief, Bruce Vladeck. The new rebased cost limitations proposed by HCFA at levels lower than the freeze period defy all logic-irrespective of any rhetoric made to defend them. Specifically, proving the new REDUCED Cost limitations defy all reasonable logic, we offer the following three points: First, the Freeze level cost caps were determined, according to the Federal Register dated February 14, 1995, "from settled Medicare cost reports, for cost reporting periods ending on or after June 30, 1989 and before May 31,1991" (the published average agency cost per visit, from HCFA, Office of the Actuary, for this time period was : 1989-$57.18, 1990-$54.85, and 1991- $56.19) ; Second, the newly published REDUCED "Post-Freeze" level cost caps were determined, according to the Federal Register dated July 1, 1996, "from settled Medicare cost reports, for cost reporting periods ending on or after June 1, 1991 and settled by October 1,1995"

(the published average agency cost per visit, from HCFA, Office of the Actuary, for this time period was : 1991-$56.19, 1992-$57.23, 1993-$60.26, 1994- $61.66 and 1995- $63.79); and Third, Table 11 in the July 1, 1996 Federal Register (entiled "HHAs Exceeding the Cost Limits) brazingly states that under these new limits 34.5% of all agencies are projected to EXCEED these new Reduced "Post-Freeze" Cost Cap Limitations. **Given these important facts, we ask that the Subcommittee instruct HCFA that the NEW Cost Cap Limitations, as published on July 1, 1996, be modified to state that where cost caps are found to be lower than the 1993 freeze levels, they be modified to equal freeze levels, plus a cost of living increase.**

SECTION III - A COMPARISON OF PPS PLANS

(A COMPARISON OF THE PPS "PER-VISIT" PLAN TO THE "PER-EPISODE")

WHY A "PER-VISIT" PPS PLAN WILL WORK

ANY PROSPECTIVE PAYMENT (PPS) PLAN SHOULD GUARANTEE FIVE THINGS:

1. **That we pay for what patients receive (Not for what they don't)**. There should be incentives to provide needed care, not incentives to deny it when our elderly need it most.
2. **That the Government has the opportunity to share in savings.**
3. **That Medicare expenditures are "truly" contained.**
4. **That Medicare fraud/abuses are curtailed.**
5. **That a Medicare Review Program is in place to ensure quality care is being given.**

HCAA'S PPS "PER VISIT" PLAN GUARANTEES SAVINGS AND QUALITY CARE:

At the very core of HCAA's proposed PPS Plan, is our guarantee to provide care to the nation's elderly at an agreed-upon national cap for home care expenditures; thereby, controlling cost increases, and realizing a savings for the Medicare program. Let's not repeat the **tragic premature implementation of PPS** in home health care that occurred in 1983 for hospitals, by implementing an untested "per-episode" DRG PPS plan, resulting in today's four-fold cost increase. HCAA proposes a PPS plan that is based on per-visit (thus, guaranteeing the incentive is on **providing** care, **not** on **denying** care). Our plan also promised the opportunity for the government to share in savings (unlike a per-episode method wherein the payment becomes the ceiling and the government is thereby denied any opportunity for savings). **To guarantee that the rate of growth for home care Medicare expenditures is truly contained, HCAA proposes that there be a national cap on home care expenditures, adjusted only for two factors**: First, an annual cost of living increase; and Second, an annual adjustment based on the actual percentage growth in the beneficiary population. HCAA's "per visit" plan calls for a payment method that is both fair (eliminates the inducements to self-refer) and offers providers incentives and abilities to self-police, and expose today's sophisticated health care abusers. Congress has already received testimony that a flat, "per-episode" pay rate (similar to HMOs/DRGs) does not have the controls and safeguards in place to ensure necessary care is given, whereas HCAA's "per-visit" reimbursement rate, based on care actually provided, already has a quality assurance program in place within the current Medicare Intermediary system.

HOW TO IMPLEMENT HCAA'S PPS "PER-VISIT" PLAN:

* *HCAAs Plan is the Only Plan With a Fail-Safe National Cap:*
Statistics are readily available for current home care expenditures nationally, by state, and by local geographic area. HCAA proposes that these be used to establish a fail-safe cap and that this would be the only manageable basis to truly establish the control on the growth in Medicare expenditures. This fail-safe national cap would be modified only for the two adjustments described above: one, a cost of living increase; and two, beneficiary growth. For management purposes, the fail-safe national cap is to be further divided by state, and then by area. To manage (and curtail) fraud/abuse HCAA recommends that, FOR THE FIRST TIME, agencies be given authority to appoint representatives to monitor monthly area claim expenditures made by intermediaries, thus forming a "WE" team between government and providers. Abuses and unnecessary services can be more readily monitored by including the providers in the enforcement process. In the event of demographic population changes, an adjustment could be made between these smaller, manageable components - without altering the national cap.

* *HCAAs Plan is based on a "Per-Visit" PPS Rate - Thus Guaranteeing Care ("Per-Visit" is similar to the "Per-Diem" method HCFA endorses for the SNF industry)*

The current visit rates are already known. A geographic phase-in can be made, similar to the DRG phase-in with the exception that a mileage factor be included, in addition to a labor factor. Additionally, to stop hospital inducements to deny patient choice, payments to hospitals need to be "lowered" to reflect administrative costs already covered in their existing hospital DRG inpatient rates. Also, three further restrictions are necessary: First, a hospital cannot be entitled to receive more than 30 percent of its own referrals and should be prohibited from receiving referrals from other community sources. Second, there can be no more than a minimal amount of independent contractors for nursing or aide services (we recommend a 10 percent ceiling on such contracts). Third, physicians may not participate in home care remunerations. There is only one exception the "sole" community provider. Also, during the phase-in period, agencies must be permitted to market their services in the community, similar to the marketing used by HMOs and other health care providers in their area (with, of course, cost caps remaining during the phase-in).

WHY A "PER-EPISODE" PPS PLAN WILL FAIL

Any PPS method based on a "Per-Episode" payment will not succeed in either reducing current Medicare costs or insuring that care is provided to the elderly. Why? Here are the reasons:

1. **"HCFA SAYS "Per-Episode" Payment is a Bad Choice.**

   On page 20 of Bruce Vladeck's July 23 testimony, he hammers out why a per-episode payment is a poor choice as a PPS plan for SNFs. His same reasoning (on page 14 of his testimony) is exactly applicable to home care; and makes one wonder why he would even consider a per-episode PPS plan for home care, except that he stated that his plan for home care would not begin to transition to PPS until 1999 (at which time more data *could* be available on case-mix adjusters, etc). Mr. Vladeck stated, ***"There is no comparable information for per-episode prospective payment system. Not only do we not have sufficient information to determine the appropriate level of payment, no research has been conducted on the effects of a per-episode payment system on patient outcomes, quality, or access to care. The incentive under a per- episode prospective payment system could be for facilities to discharge patients as quickly as possible, as facilities receive the same payment irrespective of how many days the beneficiary remains in the SNF. Earlier discharge may result in poor quality care and increased overall program costs, as beneficiaries still needing services may return to the hospital or initiate home health visits. Furthermore, in the absence of an accurate case-mix adjuster (which currently does not exist to predict per-episode costs), SNFs would have an incentive to avoid more resource-intensive patients; and access to SNF care for the beneficiaries that need it the most would be reduced."*** Every reason given here by Mr. Vladeck is identical to the problems in implementing a per-episode payment for home care.

2. **"Per-Episode" Payment** is, by definition, a flat payment based upon characterization (similar to DRGs and/or HMOs).

3. **Overwhelming evidence** shows that a PPS "Per-Episode" method will fail to:

   A. Reduce Costs
   (Both DRGs and HMOs have not saved one cent. In fact, they have proven to cost more.)

   B. Provide care
   (Both DRGs and HMOs have proven to deny care).

4. **"Per-Episode"** will result in payment for what patients don't get--not a wise decision!

5. **Caution** - ***Adopt A PPS Plan That Pays Per-Visit, Not Per-Episode***

   The most important issue that everyone agrees on is that the rate of growth of health care "costs" should be controlled; but no one feels that "services" should be denied. HCAA

implores you to reject the imposition of any PPS plan for home health care, such as per-episode payment, which is based on denying care and has no true cost control measures inherent in its design! As two bipartisan members of the subcomittee pointed out in the hearing, a per-episode method has the same inherent payment problems of HMO and hospital DRGs: denial of care and failure to control costs. It was also pointed out by the honorable Chairman that although the industry representatives testifying may like the per-episode method, there is no proof that it is a better method of controlling costs. Allow the current PPS demonstration project to be completed for home care; and consider the results. Seek home care industry input from freestanding proprietaries before PPS is implemented.

BEN FRANKLIN'S ACID TEST RESULTS

Equal a Decided NO to PPS Per-Episode and YES to PPS Per-Visit

Ben Franklin's method was to list the advantages and disadvantages in order to reach a proper decision.

THE ACID TEST	PER-VISIT (with a National Cap)	PER-EPISODE
1. Does it pay for what patients receive?	YES	NO
2. Will the government share in savings?	YES	NO
3. Will Medicare expenditures be contained as a result?	YES	NO
4. Will Medicare fraud/abuse be curtailed?	YES	NO
5. Is a medical review program in place to ensure quality care?	YES	NO

SECTION IV - OTHER ISSUE

1. STOP HMOs FROM OVERBILLING MEDICARE BILLIONS!

HCAA recommends HMO legislation to save the desired 6 percent (over $16 billion) in Medicare dollars annually, by requiring HMO Medicare reimbursements to incorporate a "case-mix" capitation adjustment. Currently, HMOs are paid an average of $4,500 per Medicare beneficiary, which was falsely computed based upon the naive assumption that HMOs would enroll a case-mix of both healthy and sick Medicare beneficiaries. Because it has now been proven that HMOs target the healthy elderly, and because these healthy enrollees cost Medicare less than $500 a year (Consumers' Research, 7/95), HMOs are costing (not saving) Medicare the billions of dollars that, alone, would keep the program solvent. For example, a "case-mix" capitation adjustment factor (i.e., payment of only $500 for healthy elderly enrollees, versus the current $4,500), would guarantee that HMOs would be paid only what it costs to provide quality care, plus a fair reimbursement for administration and profit. On Nov. 11, 1995, the GAO delivered its fourth HMO report to Congress with this statement, fully supporting HCAA's conclusion: "HMO Rate-Setting Methodology Thwarts Medicare's Efforts to Realize Savings." In fact, an NBC News expose documented that a full 90 percent of all Medicare beneficiaries cost an average of only $1,900 per year under traditional Medicare. HMOs currently overcharge Medicare $16 BILLION Annually.

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

August 6, 1996

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515-6348

Re: Supplement for the Record in the Hearing on Issues Related to Home Health Agencies and Skilled Nursing Facilities

Dear Chairman Thomas:

The following information is provided on behalf of the Home Health PPS Work Group and is intended to supplement the testimony presented by Stephen W. Holt and Phillip I. Hoffman at the hearing on Issues Related to Home Health Agencies and Skilled Nursing Facilities held on July 23, 1996.

This information is provided in response to comments and questions raised at the hearing by some members of the Subcommittee concerning the wisdom of imposing copayments on home health services covered by Medicare. Also included are some additional comments on the testimony presented at the July 23, 1996 hearing by HCFA Administrator Bruce Vladeck.

Copayments Are Bad Public Policy And Should Not Be Adopted.

The imposition of copayments on home health services covered by Medicare will not result in more cost effective health care and is less effective than prospective payment in controlling the growth rate in home health expenditures for the following reasons:

1. **Like the Part B shift, copayments create no incentives for cost effectiveness.**

   Just as with the Part B shift proposed by the Administration, copayments do not address the underlying problem which has produced the unacceptable rate of growth in Medicare expenditures for home health services. Copayments do not alter the incentives under the current antiquated cost reimbursement system for home health agencies to incur higher costs per visit, provide more visits per patient, and keep patients on service for longer periods of time. Just as with the Part B shift, copayments offer an illusory solution which obscures, rather than addresses, the defects in the current reimbursement system.

2. **Unlike PPS, copayments are a cut in the current Medicare benefit.**

   Copayments constitute a cut in the current Medicare benefit, while the unified prospective payment proposal achieves savings by reducing the rate of expenditure growth. Just as with the Part B shift, copayments also cheapen the value of the Medicare Part A benefit while not reducing the payroll taxes used to pay for that benefit.

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3. Copayments are cruel and/or ineffective in reducing expenditures.

The most often cited rationale for copayments is that they will instill "responsibility" in the patients by showing them that the care is not "free." In other words, access to home care will be reduced by inflicting economic pain. The effectiveness of that barrier to access, however, will depend on the patient's liability and ability to pay the copayment amount. Thus, a copayment will be most effective in reducing access to care for those who are poor and/or on fixed incomes.

Copayments apply only to services that have been determined, under Medicare coverage guidelines, to be covered and "medically necessary" to treat an illness or injury. Therefore, if copayments have the intended effect, they will principally deprive the poor and frail elderly of medically necessary services.

On the other hand, if copayments are covered for many of these patients by Medicaid or Medigap policies, then the patient will suffer little or no economic pain for the use of the service, and the deterrent effect of the copayments will be lost. In the case where a copayment is picked up by Medicaid an unfunded mandate would be imposed on the states. If the cost of the copayment is covered by a Medigap policy, then the cost is merely shifted to private insurance, which is often provided by a former employer as part of retirement benefits.

In fact, in its 1993 review of the landmark Rand Health Insurance Experiment, the Congressional Office of Technology Assessment confirmed that once patients entered treatment, the amount and cost of their care was largely unaffected by cost sharing and apparently was determined principally by their physician.

It has been suggested that a three-day prior hospitalization requirement, as well as copayments, might be adopted to control the increased utilization of home health services. Written testimony submitted at the hearing by ProPAC, however, showed that Medicare payments for skilled nursing facility services have been growing at a far greater rate (33% annually) than payments for home health services and that SNF services are already subject to a three-day prior hospitalization requirement and a substantial copayment after the 20th day.

It cannot be ignored that patients receiving home health services are already shouldering the bulk of the cost of the care. They are responsible for the building, the furnishings, the heat, the light, and the water, and they often furnish staff assistance through family and friends who assist with the care. All of these costs would have to be borne by Medicare if the services were furnished in a hospital or nursing facility.

In addition, copayments on home health would further compound the economic burden which home health patients are already required to sustain in the form of costs for physicians' services, medical supplies, medications, unskilled personal care, and special diets.

It is also likely that imposing a barrier to home health services through a copayment will encourage patients to remain in the hospital for longer periods, because there is no cost sharing for the first 60 days of covered hospital inpatient services. In addition, patients are more likely to be hospitalized if they forego medically necessary home health services.

4. **Copayments will have a disproportionate adverse effect on certain providers and patients.**

Copayments imposed on a prospective payment system would have an arbitrary and disproportionate adverse effect on certain groups of providers and patients. Percentage-based copayments would be difficult to administer as they would vary by MSA and non-MSA under the revised unified PPS plan, because per visit rates will vary by region. "Fixed amount" copayments would arbitrarily penalize providers in regions where the per visit rates are lower, because the copayments would constitute a larger percentage of payments.

In a cost-based system, percentage-based copayments would disadvantage agencies with higher costs per visit (such as the hospital-based agencies). A fixed amount copayment would disadvantage lower cost agencies by failing to reimburse a higher percentage of their costs.

5. **Copayments increase administrative costs without improving services.**

Copayments would require an additional billing system to be established for Medicare patients, and providers would incur substantial losses due to bad debt. Because there are millions of relatively small claims filed for home health services, the added administrative costs would be extremely high. Those costs would not be significantly lower if the copayment were "nominal," since the cost of dunning patients for payment or determining other coverage remains roughly constant regardless of the amount of the copayment.

One PPS Work Group member in Michigan has estimated that it would cost an additional $8.40 for each copayment claim paid within 30 days of submission. Non-payment of the invoice would add an additional $16.70, not counting the bad debt write-off. These costs would be legitimate and necessary expenses of providing Medicare services and would have to be included in either the cost reimbursement system or a prospective payment system. The cost of home care would thereby be driven up with no improvement in the quality or cost effectiveness of the care.

Moreover, Medicare reimbursement for copayment bad debt would erode any potential savings to the program from shifting costs to beneficiaries.

6. **Copayments increase the opportunities and incentives for fraud and abuse.**

Copayments present an incentive and opportunity for some providers to waive or fail to make a sincere effort to collect the amount billed to the patient in order to induce the patient to select their agency or obtain more services from that agency. Although providers are expected to make a good faith effort to collect copayments under Medicare (generally recognized as three dunning letters), there is no effective way to ensure that a sincere collection effort is made.

Imposition of copayments would be poor public policy for several important reasons. The unified and revised unified PPS plans were developed by the home health industry in response to Congress' challenge to develop and propose a preferable alternative to copayments. The revised unified plan, which was submitted as an attachment to Mr. Holt's testimony, is the product of 18 months of intensive work, negotiation, and compromise among numerous factions within the home health industry.

Adoption of the revised unified PPS plan as an alternative to copayments has the support of virtually the entire home health industry, including nonprofit, proprietary, hospital-based, and freestanding agencies in every state. It is unlikely that this consensus could be maintained if Congress were to renege its part of the challenge.

The revised unified PPS plan achieves the twin objectives of controlling the growth in home health expenditures while preserving access to medically necessary services. Copayments fail to achieve either objective.

Comments on Mr. Vladeck's Testimony

Several statements made by HCFA Administrator Bruce Vladeck, in our view, need clarification so that they do not lead to inappropriate policy decisions.

First, **home health services covered under Part A of the Medicare program are not "post-acute care services."** Mr. Vladeck's testimony implies that acute care services are essentially hospital inpatient services, which were intended to be covered under Part A of Medicare, and that all other services are essentially chronic or long-term care services that were intended to be covered under Part B. Test. at 5-6. These mistaken assumptions lead to the conclusion that home health services should be covered under Part A only to the extent that they follow a three-day hospitalization and that the bulk of the benefit should be shifted to Part B. Test. at 17.

In fact, these assumptions do not accurately reflect the structure of the Medicare program or the manner in which home health services are furnished today. Part A of the Medicare program only covers home health services to the extent that they are "acute care services" -- that is, services which are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." See §§ 1812(a)(3), 1814(a)(2)(C), and 1862(a)(1)(A). This is precisely the same coverage standard for hospital inpatient services. By contrast, neither Medicare Part A nor Part B cover long-term or chronic care services (with the possible exception of hospice services). See § 1862(a)(9). Thus, home health services and hospital inpatient services are both acute care services under the Medicare coverage criteria, and both are appropriately covered under Part A.

Moreover, Part B of Medicare has never been a program designed to cover long term or chronic care. Thus, transferring the bulk of the home health benefit to Part B would not be a rational policy decision even if home health were "post-acute care."

Finally, Mr. Vladeck's testimony ignores the fact that, with the discharge of sicker patients to home care (Test. at 4), home health agencies have increasingly provided **covered acute care services on a longer term basis.**

Second, neither the PPS plan in the Conference Agreement nor the industry's revised proposal "relies wholly on an untested, unreliable new payment methodology that uses an inappropriate case-mix adjuster." Test. at 15-16. Both plans are based largely on Phase II of the National Home Health Agency Prospective Demonstration Project, which was approved by HCFA and has been in operation for more than one year. Test. at 12. Thus, both the payment methodology and the design of the case mix adjuster have been approved and are being tested by HCFA. HCFA obviously believes they have merit, because it is proceeding with the next two years of the project. Test. at 12.

By contrast, the Administration has not proposed a specific prospective payment methodology and has just issued a 30-month contract for a research project to determine whether a better case mix adjuster can be developed. Clearly, there would be no time to test whatever plan might be developed before the October 1, 1999 effective date set forth in the Administration's proposal. HCFA is undoubtedly at least as prepared to implement prospective payment for home health services as it was to implement prospective payment for inpatient hospital services in 1983.

The PPS Work Group looks forward to working with Congress and the Administration to implement prospective payment for home health services in 1997.

Sincerely,

James C. Pyles

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HOMECARE

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SUPPLEMENTAL STATEMENT FOR THE RECORD

WAYS AND MEANS HEALTH SUBCOMMITTEE

HEARING ON PROSPECTIVE PAYMENT FOR HOME CARE

August 5, 1996

The National Association for Home Care (NAHC) is the nation's largest association representing home health care providers, home care aide organizations, and hospices. Our membership includes hospital-based, freestanding, voluntary, and proprietary home health agencies. NAHC strongly opposes the imposition of copays on Medicare home care services.

Home care performs an important role in the American health care system. Home care patients tend to be older and poorer than the average Medicare beneficiary, and in great need of care. Copays would penalize the most vulnerable Medicare beneficiaries because of their illnesses.

Copays are regressive and tax the sick.

The average Medicare home care patient is female, white and 75 years of age or older. Poverty rates are higher for this group than for the general population. In 1993, the median income for elderly women in this age group was $8,365, bringing the poverty rate to nearly 20 percent. Health Care Financing Administration researchers Mauser and Miller have said, "we would expect [copays to result in] decreased use of home health by low-income, non-Medicaid beneficiaries because they tend not to have medigap policies and would not be able to afford the increased cost." (Mauser and Miller, "A Profile of Home Care Users in 1992," p. 30.)

A Medicare home care copay would substantially increase the proportion the poor and near poor elderly spend on health care. For example, nearly 30 percent of all elderly Medicare beneficiaries had annual incomes of less than $10,000 in 1993, and the average Medicare home care patient received 66 home care visits in 1994. A copay of $10 per visit would add 6 percent to the 24 percent of income already spent by elderly with annual incomes below $11,000, bringing out-of-pocket spending levels to 30 percent of total income for low-income seniors.

Long-stay patients are particularly at risk because they receive the most visits and would pay the most in copays. Long-stay Medicare home care patients tend to be older, more functionally impaired, and have multiple acute and chronic illnesses. A Medicare home care copay would be a "sick tax" on this group, requiring those with the most medical needs to pay the most.

The elderly already pay high out-of-pocket health care costs, despite Medicare and Medicaid coverage.

On average, elderly households spent nearly 20 percent of their income on health care in 1994. For elderly individuals with disabilities, out-of-pocket spending for home care can be an extremely heavy burden. The Medicare home care benefit does not cover all their needs, and many seniors spend out-of-pocket for the additional care they require. In fact, elderly home care patients paid more than one-third of their home care expenses out-of-pocket in 1992.

Seniors living on fixed incomes, especially those needing intensive visits following a hospitalization, may not be able to afford home care copays. These individuals have just paid the $736 Medicare Part A hospital deductible, may have had $184 per day in charges if their hospital stay was over 60 days, and have many new prescription costs that are uncovered by Medicare, in addition to the $100 Medicare Part B deductible and 20 percent copays for doctor services and equipment. Added home care copays would be prohibitive.

Patients who cannot afford home care copays may refuse all services, or choose some of the ordered services and refuse others. For example, a stroke patient who wants to be able to communicate better and needs assistance with personal care may accept speech therapy and some home health aide services, but refuse nursing, physical therapy, and occupational therapy services, which would have taught him how to care for himself and manage his disease independently. Requiring home care patients to make these kinds of choices will not result in the best health outcomes and may prove costlier to the Medicare program.

Copays -- An unfunded mandate

About 40 percent of long-stay home care users and 24 percent of all home care users are Medicaid eligible. Copays may have the unintended effect of increasing Medicaid outlays, not only for the 20 percent of currently eligible persons, but by adding more people to Medicaid roles based on spend downs resulting from these copays. In addition, home care patients eligible for both Medicare and Medicaid may be entitled to have Medicaid cover their Medicare home care copays.

Medicaid may not protect low income home care patients.

Some states with Medicaid payment rates below the Medicare rate have refused to cover the cost of Medicare copays. Medicaid eligible home care patients in these states may not be sheltered from the additional costs of copays.

Copays would be another federal administrative burden on providers.

Home health agencies would need to develop new accounting and billing procedures, and create new software packages, as well as hire staff to send bills, post accounts receivable, and rebill.

The majority of computerized billing systems for home care are not sophisticated. Currently, home health agencies do not have data mailer capabilities, the least costly and most efficient method of billing. Without this capability, agencies will need to hire additional staff to manually prepare, stuff, and mail copay bills, in addition to posting receipts, which can cost as much as $15 per bill.

Presently, agencies can post receivables from Medicare as one lump sum for each patient when billed services are paid in full. With copays, posting home care receipts will be much more complicated. Every visit would need to be posted separately in order to provide patients with itemized statements showing dates of different copays by type (e.g. nursing, therapy, home health aide). Reimbursement specialists would be required to post these complicated multiple line items.

Data mailers, while much more efficient, will also add significant new administrative costs to home care. Data mailers would cost home health agencies 75 cents for mailing, postage, and handling of each mailer. A typical agency has 6,600 admissions per year, 75 percent of which (4950 patients) are Medicare. Most patients will receive an average of 4.5 mailers. Therefore, 22,275 mailers at 75 cents each would cost a typical agency approximately $16,700 annually to mail bills for copays for the Medicare patients.

Personnel costs for mailing, opening, posting payment, and rebilling, increase these costs by 25 cents per bill, or about $1.10 per patient admitted. At an average of 4.5 bills per patient and 25 cents per bill, annual billing costs could easily hit $27,500 for a typical agency.

In addition, federal law requires health care providers to send three statements before declaring a bill uncollectible. The national average for collecting health care copays from patients under any insurance requirement is about 60 percent; 40 percent are uncollectible. Before Congress eliminated home care copays under Medicare B, a majority of those copays, too, had to be written off to bad debt. There is also an increasing trend by patients to declare bankruptcy in response to overwhelming medical bills.

Home care patients and their families already contribute to the cost of their care.

Proponents of copayments fail to recognize the in-kind contributions home care patients and their families already make to the cost of care. With hospital and nursing home care, Medicare pays for room, board, and extensive custodial services. At home, these services are provided by family members or paid for out-of-pocket by patients without family support.

Patients and their families are already doing their part; copayments would only add to their considerable burdens. Family members often put in enormous amounts of time and energy caring for home care patients, work that would have to be done by hospital or nursing home staff. Family members frequently leave jobs so they can stay at home and provide care.

In many cases, family members are trained by home care providers to render semi-skilled support services for home care patients, such as changing dressings, giving injections, bathing and transferring patients, tube feeding, catheter care, and IVs. Medicare would have to pay for these services in hospital and nursing home settings.

Elderly Americans who received both unpaid and paid home care services in 1993 received an average of 31 hours of unpaid care from their families and friends, and 16 hours of paid assistance. Those who received some Medicare home health services in 1993 paid 28 percent of their home care expenses out-of-pocket for an average cost of $2,377.

Conclusion

The National Association for Home Care has offered Congress a proposal to enact a prospective payment system (PPS) for Medicare home care services as an alternative to home care copays. Copays would inappropriately require patients to assess their care needs based on their financial ability to pay for care. PPS for home care will place the burden on the provider, giving home care providers incentives to achieve high quality home care outcomes as efficiently as possible.

We strongly urge Congress to enact PPS for home care as an important and meaningful alternative to copays.

Revised Unified Proposal for a
Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Unified Plan for Prospective Payment System (PPS) for Medicare Home Health Services. It was developed jointly by the National Association for Home Care (NAHC) and the PPS Work Group.

This plan is a modification of the original unified plan submitted to Congress in 1995 as an alternative to Congressional movement to impose copays on Medicare home care services or to bundle home care payments into payments to hospitals. The modifications were made to the original proposal to respond to concerns about implementation feasibility raised by HCFA.

This plan incorporates the best elements of the home care PPS provisions in HR 2491 passed by Congress and HR 2530. It represents months of work and refinement by the home care industry. The plan calls for a three–phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case mix adjuster.

PPS is a more efficient, cost–effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety, or increasing out–of–pocket costs.

We invite your careful review of this proposal. If you have any questions or would like additional information please feel free to contact any of our organizations at the numbers listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202–547–7424

PPS Work Group
Jim Pyles 202–466–6550

Home Care's Plan to Implement Prospective Payment for Medicare Home Health Services

I. Home Care's Goal

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. PPS is a more efficient, cost–effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety.

PPS will be phased in over time, culminating in an episodic prospective payment system plan that should:

- o be developed cooperatively by HHS, the industry, and Congress
- o be acceptable to the industry
- o include extended care
- o be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- o be approved by Congress
- o include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o be based on a case mix adjustor that reflects the differences in cost for different types of patients

II. An Interim PPS Plan

An interim PPS plan incorporating certain elements of the Congressional and Democratic proposals (HR 2491 and HR 2530) should be implemented commencing within 6 months of enactment and continue until it can be converted to a pure episodic prospective payment system (Phase III). The interim PPS plan should be based on the industry's design and set forth in legislative language. The interim plan is implemented in phases to provide HCFA sufficient time to collect necessary data and to develop required processes and procedures. Current coverage criteria for Medicare home health services should be maintained and no coverage shifted to Part B.

III. Time Line for PPS Phase-In

Enact Legis.	Begin Data Collec	Begin Phase I Interim PPS	Begin Phase II Interim PPS	Report to Congress on Episodic PPS	Expected Implementation Phase III Episodic PPS
0	2mo	6mo	24mo –30mo	48mo	60mo

IV. PPS SPECIFICATIONS

A. Data Collection

HCFA is mandated to begin immediately to develop a data base upon which a fair and accurate case mix adjustor can be developed and implemented. The data base must be able to link case mix data with cost (and utilization) data.

The data base must include a sample sufficiently large to support the development of statistically valid estimates of payment rates and limits for the geographic area used (e.g., MSA/nonMSA, national, census region).

The data base must contain at least:

- items for the 18 category Phase II case mix adjustor
- HCFA form 485
- UB–92
- additional data items that may contribute to a more accurate case mix system, developed with industry participation (such as items from OASIS)

Payment rates and limits shall be adjusted to reflect cost of data collection

Effective date: 60 days after enactment

B. Phase-In of PPS Beginning with the Interim Plan

Phase I

Prospectively set standard per visit payment (as in HR 2491) with an annual aggregate per patient limit that applies to all visits (as in HR 2530)

Effective date: 6 months after enactment

All currently allowable costs related to nonroutine medical supplies will be included in the data base for calculating the per visit rate, per visit limit, and aggregate limits.

Per visit payment

- standard per visit rate for each discipline calculated (as in HR 2491) as follows:

  the national average amount paid per visit under Medicare to home health agencies for each discipline during the most recent 12 month cost reporting period ending on or before 12–31–94 and updated by the home health market basket index, except that the labor–related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located

- amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) an HHA can demonstrate costs above the payment rate, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- the payment rates and limits are calculated initially from the base year costs and cost limits and updated by the home health market basket index to the date of implementation; they are updated annually by the market basket index

- base year for payment rates and cost limits – 1994 (using settled cost reports)

Agency annual aggregate per patient payment limit

- base year for aggregate payment limit – 1995 utilization data for each agency

- the blended annual per patient limit is based on the reasonable cost per unduplicated patient in the base year (1994 cost per visit–updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 75% on agency data & 25% on census region data for 12 months following implementation of Phase I, then 50% agency data & 50% census region data

- the blended annual aggregate per patient limit is equal to the number of unduplicated patients served in the year multiplied by the per patient blended limit

- census region: the 9 census region geographic areas (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, Pacific)

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate per patient cap and below 125% of the census region cost/utilization experience shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limit. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

- Phase I in place 18 months (no longer than 24 months)

Phase II

Prospectively set standard per visit payment with an annual aggregate episode limit for days 1–120 (as in HR 2491); and an annual aggregate per patient limit for visits after 120 days

- o continue per visit payment as in Phase I
- o an episode is 120 days; post 120 day care is paid per visit with an annual aggregate per patient blended limit for the post 120 day period that is separate from the 1–120 day annual aggregate episode limit
- o the HHA is credited for a new episode limit if there is a period of 45 days without Medicare covered home health care services following the 120 day episode (if a patient is readmitted before a new episode can be started, the agency is paid per visit subject to the aggregate episode limit if within the first 120 days, or the separate post 120 day aggregate per patient blended limit if after 120 days)
- o the 18 category Phase II case mix adjustor is applied to the first 120 days, or a more accurate one if available
- o the per episode limit (as in HR 2491) is equal to the mean number of visits for each discipline during the 120 day episode of a case mix category in an area during the base year multiplied by the per visit payment rate for each discipline
- o the annual aggregate episode limit (as in HR 2491) is equal to the number of episodes of each case mix category during the fiscal year multiplied by the per episode limit determined for such case mix category for such fiscal year
- o the region for the episode limit – MSA/nonMSA area
- o the annual post 120 day per patient blended limit is based on the reasonable cost per unduplicated patient receiving care beyond 120 days in the base year (1994 cost per visit–updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 50% on agency data & 50% on census region data
- o the annual aggregate post 120 day per patient blended limit is equal to the number of unduplicated patients receiving care beyond 120 days in the year multiplied by the per patient blended limit
- o the current certification and coverage guidelines continue

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate episode and post 120 day per patient caps; and the post 120 day per patient payments below 125% of the census region cost/utilization experience, shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limits. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

Phase III (as noted under the goal in section I)

Per Episode PPS

- o developed cooperatively by HHS, the industry, and Congress
- o acceptable to the industry
- o includes extended care
- o must be submitted to Congress one year in advance of implementation and within 4 years of enactment of legislation
- o approved by Congress
- o adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o case mix adjustor that reflects the differences in cost for different types of patients

C. Additional Specifications that Apply to All Phases

1. **Exceptions:** The Secretary shall provide for an exemption from, or an exception and adjustment to, the methods for determining payment limits where extraordinary circumstances beyond the home health agency's control including outliers and the case mix of such home health agency, create unintended distortions in care requirements not accounted for in the case mix adjustor payment system. The Secretary shall develop a method for monitoring expenditures for such exceptions. Methods should be developed to allow for additional home care expenditures when they are found to decrease total Medicare expenditures.

2. **Quality:** Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by implementing a revised survey and certification process which emphasizes patient satisfaction and successful outcomes.

   Home health agencies will be required to provide covered services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

   There will be established a means for beneficiary due process to challenge care and coverage determinations first through internal provider grievance procedures, then through external PRO review.

   There will be established a mechanism for quality review for instances of significant variation in utilization by providers. (this can address both visits and admissions)

HOME HEALTH INDUSTRY'S REVISED UNIFIED PPS PLAN (MARCH 1996) • CONGRESSIONAL, DEMOCRATIC, AND UNIFIED PLANS COMPARED

Page 1 of 2	Current Law	Congressionally-Passed Plan (H.R. 2491)	Democratic/Administration Alternatives (H.R. 2530)	Revised Unified PPS Plan
1. Core Concept	Per visit cost-based reimbursement, subject to cost per visit limits.	PPS with per visit payment subject to aggregate per episode limit.	Per visit cost reimbursement with lower cost limits and annual aggregate per beneficiary limit until FY 2000, per episode PPS (to be developed) thereafter.	PPS with per visit payment subject to annual aggregate per patient limit; after 18–24 months change to aggregate per episode limits on payments for first 120 days of care; episodic PPS after 5 years.
2. Implementotion Dote	Currently in effect.	October 1, 1996.	New cost limits effective 10/1/96, per episode PPS effective 10/1/99.	Beginning six months after enactment, phased in over 24 months.
3. Payment System	Cost-based reimbursement, subject to cost per visit limits.	PPS based on a flat per visit payment rate (by discipline) subject to an agency aggregate episode limit (as described in #8 and #9 below).	Interim payment system based on reasonable cost per visit payments subject to an aggregate per patient annual limit until 10/1/99 then switch to a pure per episode PPS.	Interim PPS based on a flat per visit payment rate (by discipline) subject to agency aggregate limits; in Phase I: aggregate annual per patient limit; in Phase II: aggregate episode limit for 0-120 days and aggregate annual per patient post 120 day limit.
4. Converts to per episode PPS	N/A	No conversion to pure per episode PPS.	Pure per episode PPS to be developed and implemented by 10/1/99.	Converted to episodic PPS approximately 5 years after enactment based on HCFA/industry design.
5. Poyments to HHAs	Per visit cost reimbursement, subject to retroactive cost disallowance.	National per visit rates regionally adjusted. Flat rate equal to the national average amount paid per visit for each discipline with labor portion adjusted for MSA/non MSA area.	Reasonable cost per visit up to a cost limit and annual aggregate per beneficiary limit until 10/1/99, with payments based on per episode PPS thereafter.	National per visit rates, regionally adjusted. Flat rate equal to the national average amount paid per visit for each discipline with labor portion adjusted for MSA/non MSA area; payment up to a limit when certain conditions met.
6. Limits on Payments	Per visit cost limits, excluding hospital-based data. Per visit cost limits equal to 112% of the mean. Applied in the aggregate.	Aggregate per episode limit for first 165 days, no limit thereafter.	Per visit cost limits of 112% of mean with labor portion adjusted for MSA/non MSA area (the Administration proposed 105% of median) and annual aggregate per beneficiary cap until 10/1/99, then per episode payments.	Annual aggregate per patient limit for all payments during first 18–24 months; in Phase II, aggregate per episode limit on payments for services 0-120 days and per patient limit post 120 days; Phase III, per episode payments.
7. Episode Definition	N/A	120 days preceded by 60 days without home health services.	Time limited episode not used; the per patient limit is on annual limit (if a patient continues on service into a new fiscal year another per patient limit is allocated).	In Phase II episode defined as 120 days preceded by 45 days without Medicare-covered home care services. In Phase III to be determined.
8. Episode Limit	N/A	Determined for each case-mix category in an MSA/non MSA area and is equal to the mean number of visits for each type of service furnished in an episode in FY94 adjusted by the case-mix adjustment factor and multiplied by the per visit payment rate for each type of visit; if an area has an insufficient number of agencies the Secretary can designate another area.	Starting 3 months after implementation the per patient annual limit is changed from agency specific to a blended limit based 75% on the agency specific reasonable cost per patient per year and 25% on the census region (or national) reasonable cost per patient.	Phase I: annual per patient limit based 75% on agency data and 25% on census region data for 12 mos., then 50%-50% blend; Phase II: 1) episode limit based on number of visits in and episode by case-mix category in the MSA/non MSA region multiplied by the payment per visit: 2) post 120 day annual per patient limit based on a 50%-50% blend of agency and census region data.
9. Calculotion of Aggregote Limit	N/A	Aggregate episode limit is the sum of the products of the number of episodes for each case-mix category multiplied by the per episode limit for such category.	Annual aggregate per patient limit equals the product of the per patient limit multiplied by the unduplicated census count of Medicare patients.	Annual aggregate per patient limit and post 120 day per patient limit calculated by multiplying the number of unduplicated Medicare patients by the per patient limit; aggregate episode limit is the sum of the products of the number of episodes for each case-mix category multiplied by the per episode limit for such category.
10. Application of Visits to the Limits	N/A	Visits after the first 120 days are paid per visit; however, visits on days 121-165 are applied to the aggregate episode limit which is based on the average cost for 120 days; after day 165, visits are not applied to the limit.	Aggregate limit based on average reasonable cost per patient per year for all visits including services beyond 120 days.	The time periods for applying visits to limits are the same as the time periods on which the limits are calculated (no gaps).
11. Base Year	N/A	1994: visit rate based on data from most recent 12 month cost reporting periods ending on or before 6/30/94 (not updated to 10/1/96); episode limits based on the mean number of visits per episode in FY94.	1994: per patient limit calculated from 12 month cost reporting periods ending on or after 1/1/94 and on or before 12/31/94 (updated by the market basket index to 10/1/96).	1994 for cost per visit (updated by market basket index to implementation date); 1995 for utilization.

Draft: July 23, 1996

Page 2 of 2	Current Law	Congressionally-Passed Plan (H.R. 2491)	Democratic/Administration Alternatives (H.R. 2530)	Revised Unified PPS Plan
12. Updates	Cost limits updated annually.	Per visit payment rates and per episode limits are updated annually by home health market basket minus 2 percentage points.	Per patient limit updated annually by the market basket index; per visit payment rates based on reasonable cost up to the cost limits; cost limits calculated annually.	Per visit payment rates, per visit payment limits, and per patient/episode limits updated annually by the home health market basket index.
13. Rebasing	N/A	Rebase per visit payment rates and episode limits in 1999, then every 5 years.	In the interim system, no rebasing of per patient annual limits; cost limits are calculated annually; the payment rates are reduced by 15% with the implementation of per episode PPS 10/1/99, unspecified thereafter.	No rebasing.
14. Incentives for Cost Effectiveness	None	50% of the difference between total visit payments and the aggregate limit up to maximum of 5% of total payments.	50% of the difference between reasonable costs and the aggregate limit up to a maximum of 5% of total reasonable cost, if the agency cost/utilization experience is below 125% of the mean cost/utilization experience per patient in the census region (or nationally).	50% of savings up to a maximum of 10% of total per visit payments; same limitation (125% of census region mean) in Phase I and post 120 day in Phase II as in HR2530.
15. Case Mix Adjustment	N/A	18-category case-mix adjuster from home health PPS demonstration project.	Interim system does not use a case-mix adjuster—agency specific costs used to account for each agency's case mix; case-mix adjuster implemented in 10/99 with per episode PPS.	Phase I: same as HR 2530; Phase II: first 120 days same as HR 2491; post 120 days as in HR 2530; Phase III: new case-mix adjuster based on research.
16. Tracking Patients	N/A	Track home health patients that switch agencies and adjust payments to ensure that aggregate payments do not exceed what would be paid to a single agency.	If services provided by more than one agency, per patient limit prorated among the agencies.	Track home health patients that switch agencies and adjust payments to ensure that aggregate payments do not exceed what would be paid to a single agency.
17. Payments for Non-Routine Supplies	Reimbursed on a cost basis.	Not specified.	Included in average cost per patient.	Allowable costs for nonroutine supplies included in the database to develop payment rates and limits.
18. Certification	On admission, and every 62 days thereafter.	Recertification by intermediaries at 60 and 165 days.	Same as current law.	Same as current law.
19. Exceptions/Exemptions	Unlimited exceptions allowed for reasonable costs beyond the agency's control.	Limited to 1994 amounts increased by the home health market basket percentage increase for the fiscal year involved.	Not included.	Exceptions allowed for circumstances beyond the agency's control. Total amount limited to funding from non-agency share of savings.
20. Low Cost Cases	N/A	Develop a system to adjust payments to an agency for an increase in percentage of low cost cases.	Not included.	Monitor significant changes in distribution of both low and high cost cases.
21. Case Mix Adjustment Factor	N/A	Case-mix adjustment factor to assure that aggregate home health payments do not exceed previous year's payments as a result of changes in the number and type of visits within categories for 1997-2000; for subsequent years, a factor determined by the Secretary necessary to remove the effects of case-mix increases due to reporting improvements instead of real changes in resource usage.	Not included.	Not included.
22. Fail-safe	N/A	Contains mechanism to trigger an automatic across-the-board cut in home health care payment rates if total deficit reduction targets are not met. Mechanism cuts approximately $2.1 billion from home health expenditures over 7 years in addition to PPS savings. (CBO, Nov. 22, 1995).	No fail-safe.	No fail-safe.
23. PPS Scored Savings	None	$14.2 billion over 7 years. (CBO, Nov. 16, 1995).	$8.7 billion over 7 years. (CBO, Dec. 15, 1995)	Comparable to HR2530 and Administration's plan.
24. A to B Shift	Full coverage under Part A.	Full coverage under Part A.	2530: Part A covers up to 150 days during any spell of illness. Part B covers thereafter. Admin: Part A covers up to 100 visits following 3-day hospital stay. Part B covers all other visits.	Full coverage under Part A.

Declaration of Support

* * *

Declaration of Support for Implementation of a Prospective Payment System for Medicare Home Health Services

July 17, 1996

Whereas the health care industry is facing rapid and significant changes both in the delivery of services and its relationships with payors;

Whereas the health care delivery system is increasingly relying on some form of managed care to encourage providers to achieve patient centered, favorable outcomes in the most cost effective manner possible;

Whereas the current structure of cost reimbursement for Medicare home health services is counter productive to the goals of delivery high quality, cost effective, and medically necessary services;

Whereas the home health industry must move to a Prospective Pay system to operate more consistently with non-Medicare reimbursement systems;

Whereas the Congress and the Administration have indicated that the rate of expenditure growth in the Medicare home health benefit, combined with the overall financial state of the Medicare program, requires the adoption of some measure to reduce the growth rate in Medicare home health expenditures per patient in future years;

Whereas the home health industry considers copayments, at any level, an unacceptable and improper burden on the infirm elderly and disabled who receive Medicare home health services given the significant contributions made by these individuals and their families make as primary caregivers in the home setting;

Whereas the home health industry considers proposals to "bundle" home health payment with other Medicare payment, such as hospital services, to be inappropriate and counterproductive in achieving the goal of providing care in the most cost effective setting possible;

Whereas the Congress has requested the home health industry to offer a substitute for copayments and bundling that provides incentives for reducing the rate of expenditure growth while preserving access to medically necessary home health services;

Whereas the home health industry considers the implementation of a Prospective Pay system to be the appropriate mechanism to address the needs and concerns of patients, the Medicare program, and the home health industry;

Be It Resolved that the following organizations, comprised of the National and State Associations representing the interests of Medicare certified home health agencies, and the patients they service, nationwide commit their support for the enactment and implementation of a Prospective Payment system which is entitled "The Revised Unified Plan", as attached hereto.

Signed,

Home Health Services and Staffing Association

National Association for Home Care

Visiting Nurse Associations of America

Alabama Association of Home Health Agencies

Alaska Home Care Association

Arizona Association for Home Care

Home Care Association of Arkansas

Home Care Association of Colorado

Connecticut Association for Home Care, Inc.

Delaware Association for Home and Community Care

Capital Home Health Association

Associated Home Health Industries of Florida, Inc.

Georgia Association of Home Health Agencies, Inc.

Georgia Association of Community Care Providers

Hawaii Association for Home Care

Idaho Association of Home Health Agencies

Illinois Home Care Council

Indiana Association for Home Care, Inc.

Iowa Association for Home Care

Kansas Home Care Association

Kentucky Home Health Association

Homecare Association of Louisiana

Home Care Alliance of Maine

Maryland Association for Home Care, Inc.

Home & Health Care Association of Massachusetts

Massachusetts Council for Home Care Aide Services

Michigan Home Health Association

Minnesota HomeCare Association

Mississippi Association for Home Care

Missouri Alliance for Home Care

Montana Association of Home Health Agencies

Nebraska Association of Home and Community Health Agencies

Home Health Care Association of Nevada

Home Care Association of New Hampshire

Home Care Council of New Jersey

Home Health Services and Staffing Association of New Jersey

New Mexico Association for Home Care

Home Care Association of New York State, Inc.

New York State Association of Health Care Providers, Inc.

North Carolina Association for Home Care, Inc.

North Dakota Association of Home Health Services

Ohio Council for Home Care

Oklahoma Association for Home Care

Oregon Association for Home Care

Pennsylvania Association of Home Health Agencies

Puerto Rico Home Health Agencies

Rhode Island Partnership for Home Care, Inc.

South Carolina Home Care Association

Tennessee Association for Home Care, Inc.

Texas Association for Home Care

Utah Association of Home Health Agencies

Vermont Assembly of Home Health Agencies

Virginia Association for Home Care

West Virginia Council of Home Health Agencies, Inc.

Wisconsin Home Care Organization

Home Health Care Alliance of Wyoming

Approval Pending:

South Dakota Home Health Association

Home Care Association of Washington

Testimony of
James L. Scott
President, Premier Institute
Premier, Inc.
400 N. Capitol Street, NW, Suite 590, Washington, DC 20001-1511

Submitted to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
on Medicare Payment Policies for Home Health and Skilled Nursing Facility Care
July 23, 1996

Mr. Chairman and Members of the Subcommittee, on behalf of Premier, Inc., which represents major integrated delivery systems across the country and one-third of the community hospital beds in the nation, I am pleased to have the opportunity to share our views about Medicare payment policies relating to postacute care services, especially home health and skilled nursing facility (SNF) care. I would like to begin by commending Chairman Thomas for convening this important hearing and for according attention to needed reforms in Medicare payment for home health and SNF services. As this Subcommittee well knows, Medicare expenditures for these services have been rising much more rapidly than outlays for most other facets of the program. Moreover, the proportion of Medicare patients receiving home health and SNF care, and the average amount of such care per patient, are rising.

For nearly fifteen years, Medicare has paid for inpatient hospital care on a prospective, per-case basis, using a diagnosis-related classification system. In contrast, Medicare continues to pay for home health and SNF services using a cost-based methodology. While the Health Care Financing Administration (HCFA) has supported a great deal of research and undertaken several demonstration projects in the hope of devising separate, prospective payment policies for home health and SNF care, we are concerned that they have given insufficient attention to a much more promising approach, i.e., rebundling payments for postacute care into the existing hospital prospective payment system (PPS). Given Congressional interest in increasing the use of capitated arrangements for Medicare beneficiaries in a wide range of integrated care organizations, it would seem that the bundling of home health and SNF services into the existing PPS is preferable to investing considerable resources in separate, fee-for-service payment methodologies for these services, especially methodologies that result in payment on a per-diem or per-visit basis, rather than on a more global basis (e.g., per case). At the very least, it would seem prudent for Congress to direct that the same level of resources be devoted to developing a rebundling policy as in devising other alternatives.

Obviously, third party payors (including Medicare) are interested in bundled payment arrangements because they guard against overuse of services, especially where the individual bundles capture a large range of services provided over a long period. And payors are likely to want the simplest (and most comprehensive) bundling arrangement possible, rather than many, relatively small service bundles each provided by a different entity (and requiring a separate contract or other business arrangement).

Under a rebundling approach, a hospital could receive a single payment for both the costs of an inpatient stay and necessary postacute services (e.g., SNF, home health and rehabilitation) and would be responsible for ensuring that the patient received all necessary care. Of course, the bundling of SNF care into Medicare's hospital PPS would make the ongoing nursing home prospective payment demonstrations largely irrelevant since a prior three-day hospital stay is a prerequisite for Medicare coverage of SNF services and, thus, all Medicare-covered SNF services would be rebundled into PPS. It would also lessen the importance of the ongoing home health prospective payment demonstrations, since a large proportion of the Medicare beneficiaries receiving home health services have had a preceding hospital admission and these services would also be rebundled into PPS. For example, in 1992, about two-thirds of Medicare home health users began their episodes of care within 30 days of being discharged from a hospital. Finally, rebundling would obviate the need for other

planned refinements in SNF and home health payment policies, including the adoption of revised salary equivalency guidelines for rehabilitation services provided under arrangements to SNF patients.

In designing an appropriate postacute care rebundling methodology, four key tasks would need to be accomplished: (1) defining the bundle of services to be covered; (2) identifying an appropriate patient classification system for payment purposes; (3) developing a method for determining the appropriate payment amounts and settling a variety of related issues (e.g., the need for exceptions or outlier payments, and the method for adjusting payments for geographic considerations); and (4) settling the question of which entity or entities should receive payment for the bundled postacute services. With respect to patient classification, the system of diagnosis-related groups (DRGs) already in use appears to provide a ready-made solution. Over time, it may be necessary to further refine the DRG classification system to account for differences in the postacute care needs--and costs--of patients now classified in the same DRG. However, such refinements would be no different that the many other changes in the classification schema that have already been made for a variety of reasons.

Of course, the rebundling of postacute care undoubtedly would raise questions about the impact on quality of care, treatment outcomes, and utilization of services. Moreover, consideration should be given to the need for changes in existing Medicare statutory and regulatory requirements, and appropriate beneficiary coinsurance and copayment obligations for the rebundled postacute care services would need to be devised.

If payment for postacute care were bundled into the hospital inpatient PPS, the result would be a single responsible entity (the hospital), which would no longer see its obligations to the patient end at the time of discharge. Such rebundling would also give hospitals more flexibility in deciding how best to meet a patient's needs, and in what setting.

In short, while we recognize that rebundling postacute care into PPS raises a number of issues, such an approach appears to present clear advantages over continued reliance on per-diem, per-visit or other relatively fragmented payment methodologies, where multiple providers share responsibility and where it is conceivably easier for an individual patient to "fall between the cracks," or for one provider to shift a care burden to other providers, perhaps in response to the incentives provided by Medicare payment policy. Moreover, the long-term plan for Medicare envisions an expansion of private health plan options for beneficiaries, including provider-sponsored networks, with payment made to a single responsible party on a purely capitated basis for *all* Medicare-covered services. In light of this, rebundling postacute care into PPS certainly appears to be a move in the appropriate direction. Congress should consider mandating such a change by directing HCFA to test the concept in both urban and rural settings.

JOINT STATEMENT OF
RAYMOND N. ALTIERI, BURGESS A. HARRISON,
DAVID S. COLE, AND JOHN P. CLARK, ESQ
ON BEHALF OF STATCHEK

STATEMENT OF SUBMISSION NO. HL-21

August 5, 1996

INTRODUCTION

The prospect of PPS as the Medicare reimbursement system for homecare will clearly have a major impact on the homecare industry. Accordingly, many private sector firms are positioned, or are beginning to position themselves to help the industry to implement the changes necessary for successful implementation of PPS.

Homecare has clearly proven its value as an alternative to institutionalized care. It has provided a means by which acute care centers can discharge patients to less costly intermittent care much sooner than previously possible. Virtually all referrals of patients to homecare come from acute care centers. Therefore, expansion in the percentage of the total Medicare Part A expenditures for homecare, from 4% in 1989 to 13% in 1995 must be viewed in terms of the corresponding savings realized in acute care costs. Accordingly, this increase is a positive move by acute care centers that can reduce the in-patient and therefore overall Medicare costs for an episode of care. The recent trend towards earlier discharges from acute care centers to homecare agencies may be more closely related to current reimbursement policies than concern over patients' cost of care. However, the result is still the same, a less costly episode of care for Medicare.

Homecare is more than just a cost effective way of minimizing acute care stays. It allows patients to recover in the most comfortable and familiar surroundings, limits reimbursed care to clinical necessities and further offsets acute care costs by involving the patient's family in the recovery.

THE PROBLEMS

Stronger care management is necessary, and clearly the focus on minimizing acute care stays must and should continue. However, to be effective any new reimbursement system must address three critical issues.

First, and most importantly, prospective pay shifts the burden of "rationing" care to the provider agency. PPS must account for this and assure that provider agencies continue to provide the quality, quantity and frequency of visits necessary for patients to achieve the desired outcome. If the new system results in an increase in recidivism rates, the result of the entire program could be substantial increases in the net cost to Medicare for patient recovery.

Second, the system must return factual, objective data to Medicare, from which it can manage the system from a quality assurance perspective. It is critical in the administration of any managed care system to have truly objective data in order to know if the target reimbursement rates for the various diagnostic codes are accurate. That means that Medicare must know how many visits of what type and duration are really necessary to bring a patient from acute care discharge through homecare to the desired outcome level. Without this information, perspective pay can be no more effective than the current "fee for service" system.

Third, PPS has been designed to place "reasonable" financial limits on the costs of services which provider agencies deliver to patients. To assure these providers can continue to service patients and deliver an adequate level of care under the new system, the providers must become more efficient. Efficiency is not easily obtained and will require cooperation between Medicare and provider agencies to be achieved.

One of the major problems in homecare is the inefficiency inherent in providers' operation and management of their agencies. As a company experienced in working with agencies throughout the nation of all types, from hospital based to government based, from VNAs to privately owned agencies, and from sizes ranging from less than 10,000 visits per year to those delivering in excess of 1,000,000 visits per year, we possess knowledge which rises from our experience with many different levels of provider efficiency. We find that most agencies do not benefit from an economy of scale. Rather, they maintain a direct relationship between the number of field staff and the number of office/support personnel. While most agencies are in the range of four to seven field workers per office/ support staff person, the paradigm ranges from 1:2 in the worst cases to 1:20 in the best. This ten-fold difference in efficiency translates to potentially huge savings when extrapolated throughout the industry.

Inefficiency in homecare agency operation can be directly linked to the nearly unmanageable myriad of paperwork and requirements established by the various federal, state local and private pay sources. PPS must address these areas as well.

ANALYSIS

The first two issues, quality assurance and accuracy in determination of reimbursement rates, must be centered and based upon objective data to work successfully. The third issue, efficiency, can also be somewhat addressed through the collection and analyses of objective data. The problems then that must be solved are: how to collect the data, centrally, accurately and timely, while also reducing the reporting and record-keeping burden, all while helping provider agencies improve their efficiency. If PPS fails to achieve any one of these goals it cannot succeed.

There are solutions that exist today that can assure data is collected quickly and accurately, directly from the point of care. Some of these solutions also address the other issues of quality assurance, efficiency and reduced administrative overhead.

Implementation of PPS in and of itself will not solve the issue of escalating volume and utilization within SNF benefits as covered under Medicare. What is needed is a true public/private partnership as PPS is implemented within the industry. It is our position that the partnership should seek to outline, develop and deploy the tools necessary to assure PPS achieves its goals in a practical manner. Fixing the cost for each diagnostic code, as the plan in essence does, only serves to push down the reimbursement and shift the "rationing" of care to the provider without regard for how services are delivered and the subsequent outcome or quality of care.

PPS assumes that if costs are capped providers will focus on the quality of service and outcome. yet recidivism to acute care facilities could easily become the preferred outcome (or the only financial viable alternative) under PPS.

Certain implementation and execution tools are needed that would coincide with the introduction of PPS. These tools would work in tandem with other quality improvement efforts in place or planned such as OASIS, Medicare's outcome measurement system.

Numerous discussion, research and hearings have been held regarding imbedded waste, fraud, abuse and inefficiencies within the system PPS, won't stop the inefficiencies. The public sector, through HHS and HCFA, can support provider efforts to increase efficiencies within their organizations. For example, a stronger emphasis on the Paperwork Reduction Act would be a good first step. Tools and systems already exist within the industry to achieve some of the goals of the act. The government

should help providers through incentives for those willing to implement fraud-free data collection systems versus traditional, paper-based, manual processes.

One key component of the proposed PPS is the development of rate limits determined by a national average and adjusted for regional differentials in overhead and labor costs. Although this method recognizes that differences exist between various areas of the country, it does not go far enough. National and regional benchmarking of home health agencies should include components that are gathered independent of the agency in order to put labor cost data into perspective. This additional data will help provide another dimension to the determination of rate limits so that inefficiency isn't rewarded through higher rate limits. Additionally, agencies should benefit from the ability to compare key performance indicators with peer agencies in their region and with best practices on a nationwide basis. Independently collected data that is confidential and verifiable is key to the validity of this process.

RECOMMENDATIONS

From the private sector, firms already have entered the market with systems that automate homecare providers' data collection. Government agencies and legislators should seek to support these efforts and assist providers in their implementation of such systems. They should also work cooperatively with these firms and providers to exchange ideas and plans as they relate to PPS and other initiatives.

It is recommended that the following areas be addressed in any PPS scenario and be included in the overall PPS planning and implementation process:

- automated, third party, independent verification of service delivery;
- reliable, accurate and automated capture of objective data from field workers, directly from the point of care;
- automated recording and capture of outcome event data from the point of care;
- timely provision of all data to HCFA;
- greater ability for home health care agencies to track and predict their actual costs on a "per diagnostic code" basis;
- methods for determination of worker utilization and performance measures in order to pro-actively address substandard care delivery during, rather than after the conclusion of an episode of care.

CONCLUSION

It is in our nation's best interest for government and private industry to work together on the overall improvement in cost, productivity, quality and efficiency of home health agencies. These factors must be addressed concurrently in order to have any chance of long term success. There is little value in changing the system if the result forces homecare agencies to deliver the cheapest, lowest quality services. As in private industry, manufacturers often work hand in hand with their suppliers in a team effort to reduce overall production costs. To truly obtain cost benefits these cooperative efforts also incorporate quality circles or other quality improvement programs, since industry knows very well that lower costs are usually derived only with higher quality production system and products.

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STATCHEK, INC.

The aforementioned recommendations are not presented in the absence of a solution. In fact a number of home health care agencies across America have begun to move through an evolutionary path towards complete automation of their operations with services from StatChek, Inc. of New Haven, Connecticut.

For over three years, StatChek has provided information management solutions exclusively to the homecare industry through its HomeKey Service. Using a unique combination of software, telecommunications and interactive voice response, StatChek has forged an innovative solution to age old industry issues. The problems solved include: assuring visits were actually delivered as claimed, determination of actual starting and ending times and duration of visits, elimination of paperwork through verified and automated capture of visit data directly from patients' homes, benchmarking provider agencies and their workers, and the application of technology to reduce administrative overhead.

Homecare agencies in over 12 states so far, are moving down a path of automation that best meets their individual and unique needs. Now that a process such as HomeKey has been designed, tested and market proven under real conditions, the nation has an opportunity to equip all homecare agencies with similar cost efficiency tools.

The Company has participated in numerous industry events and is a member of the National Association for Home Care and the Home Care Association of America. Company principals have been published in industry trade journals and spoken at industry-wide meetings. This industry involvement coupled with continuous input from clients has served to develop and shape the Company's HomeKey Service to meet the specific needs of the home health industry.

A number of agencies already receive the benefits described within this written submission. However, the full benefit of this service, to the country and the industry can only be realized when providers can use the service to exchange visit information directly with the Medicare system.

Other software companies are providing various types of automation solutions to the industry as well. HCFA needs to recognize that American ingenuity is at work and should take advantage of those efforts that exist or are in planning within the industry to help it achieve its objectives of being the most efficient, effective and well managed care delivery system in the world.

As a company dedicated to serving the information management needs of the homecare industry, StatChek stands committed to working with HCFA and other governmental agencies as PPS is implemented.

ISBN 0-16-055313-X